

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Anne's Residential Services - Group D
Centre ID:	OSV-0003947
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Simon Balfe
Lead inspector:	Louisa Power
Support inspector(s):	Noelle Neville (Day 1 only)
Type of inspection	Announced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
14 July 2016 08:00	14 July 2016 17:30
15 July 2016 08:30	15 July 2016 15:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
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 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection;

This was an 18 outcome inspection carried out to monitor compliance with the regulations and standards and to inform a registration decision.

How we gather our evidence;

Inspectors spent time with five residents. Some residents did not use verbal communication. Residents with whom inspectors spoke were very complimentary of staff and the house manager. Residents described that they were facilitated to be active members of the local community and were very happy living in the centre.

Inspectors observed that residents were comfortable in the presence of staff. Staff were very familiar with all residents' means of communication. Assistance and support was provided in a dignified and respectful manner. Residents were observed to be offered meaningful choice and their choices were respected.

Inspectors met and spoke with staff members. Inspectors observed practices and reviewed documentation such as plans of care, medical records, accident logs, policies and procedures.

Inspectors also reviewed resident and relative questionnaires submitted to the Health Information and Quality Authority (HIQA) post inspection and their feedback is included in the report.

Interviews were carried out with the person in charge, house manager, clinical nurse manager and person nominated on behalf of the provider.

Description of the service;

The provider must produce a document called the statement of purpose that explains the service they provide. Inspectors found that the service was being provided as it was described in that document. The centre comprised two adjoining two storey semi-detached houses (Service Unit A and Service Unit B) located in a mature housing development. The housing development was in the outskirts of a large town and was within walking distance of local amenities. Two residents lived in Service Unit B and had been assessed as being semi-independent. Three residents lived in Service Unit A and had been assessed as requiring sleepover staff at night. The centre provided single occupancy en-suite bedrooms for the residents as well as communal living facilities. The service was available to adult men and women with mild and moderate intellectual disabilities. The centre supported residents with a variety of health care needs including epilepsy and diabetes.

Overall findings:

Overall, inspectors found that residents had a good quality of life in the centre and the provider had arrangements to promote the rights of residents and the safety of residents.

Inspectors found major non-compliances in two core areas. Inadequate measures were in place to contain fire as fire resistant doors were not installed in the centre and the provider was required to provide a report from a suitably competent person in relation to the fire safety measures in place in the centre. The person in charge did not meet the requirements of the regulations at the time of the inspection.

Inspectors were satisfied that the provider had put systems in place to ensure that the regulations were being met in many areas. The person nominated on behalf of the provider did demonstrate adequate knowledgeable and competence during the inspection and inspectors were satisfied that he was a fit person to participate in the management of the centre.

This resulted in positive experiences for residents, the details of which are described in the report.

Good practice was identified in the following areas:

- strong links with family were promoted (outcome 3)
- admissions were safe (outcome 4)
- robust safeguarding practices (outcome 8).

Improvements were required in the following areas:

- plans of care relating to health care (outcomes 5 and 11)
- premises maintenance (outcome 6)
- staff training (outcome 17).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the 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):

No actions were required from the previous inspection.

Findings:

Residents with whom inspectors spoke and interacted with stated that they felt safe and spoke positively about their care and the consideration they received. Interaction between residents and staff was observed and inspectors noted staff promoted residents' dignity and maximised their independence, while also being respectful when providing assistance.

Systems were in place to promote the involvement of residents and their representatives in the centre. Regular monthly house meetings took place. Minutes of these meetings were reviewed by an inspector. Items discussed included menu choices, activities, day service, upcoming local events, personnel changes and holidays. The meetings were also used as a forum to educate residents in relation to making a complaint, their rights and healthy eating. Minutes indicated that the house meeting was a meaningful and effective forum with each resident given the opportunity to communicate their views.

Staff were observed to provide residents with choice and control by facilitating residents' individual preferences in relation to their daily routine, meals, assisting residents in personalising their bedrooms and their choice of activities. Residents were encouraged to choose their activities. Inspectors saw that steps were taken to support and assist residents to provide consent and make decisions about their care and support.

Inspectors observed that residents were supported in a dignified and respectful manner. Residents' capacity to exercise personal independence was promoted. For example, residents' ability to perform tasks in relation to personal hygiene and dressing was identified and residents were encouraged to perform these tasks.

Residents were encouraged to maintain their own privacy and dignity. Staff were observed to knock on bedroom doors before entering. An en-suite shower room was provided for each resident. A shared bathroom was located on the first floor of each service unit which offered residents the choice of a bath if they wished. However, locks were not provided on the doors of the downstairs toilet facilities to facilitate all residents to adequately maintain their privacy and dignity.

The intimate care policy, dated May 2015, outlined how residents and staff were protected. An intimate care check list was completed for each resident which informed the plan of care in relation to intimate care. The intimate care plan was reviewed regularly. The plan outlined in detail the supports required, resident's preference in relation to the gender of staff delivering personal care. However, the plan of care for one resident did not reflect the check list in relation to supports required for some intimate care tasks and this was confirmed by staff.

Residents' personal communications were respected. Residents reported that they could access the telephone provided in the centre at all times. Wireless internet was provided throughout.

There was a complaints policy which was also available in an accessible format and had been reviewed in February 2015. The complaints policy identified the nominated complaints officer and also included an independent appeals process as required by legislation. The policy was displayed prominently and inspectors saw that the complaints procedure was discussed with residents. Residents with whom inspectors spoke outlined that they had never had to make a complaint but were aware of the process if they wished to make a complaint. An inspector reviewed the complaints log detailing the investigation, responses and outcome of any complaints. The complaints form also recorded whether the complainant was satisfied. No complaints were recorded in the centre and this was confirmed with residents and the person in charge. The person in charge demonstrated a proactive approach to complaints management and outlined that he would respond to any complaints in an effective and timely manner.

Residents were encouraged and facilitate to retain control over their own possessions. There was adequate space provided for storage of personal possessions. Records in relation to residents' valuables were maintained and updated regularly in line with the centre-specific policy. Residents were supported to do their own laundry if they wished and adequate facilities were available.

Residents had easy access to personal monies and, where possible, control over their own financial affairs in accordance with their wishes. Money competency assessments were completed annually for each resident which outlined the supports and training needs, if any, required. Staff outlined a transparent and robust system for the management of residents' finances who required support in this area. An itemised record of the all transactions with the accompanying receipts was kept in a ledger. Each resident was noted to have their own ledger with corresponding receipt book. The ledger balance matched the actual balance of funds available to each resident and the ledger was noted to be signed by two members of staff at each transaction. The house manager informed inspectors that staff complete a monthly reconciliation sheet and

submit this to the finance department for review. A reconciliation sheet was viewed by inspectors. The house manager confirmed that there were never any discrepancies or issues with residents' finances.

Residents are facilitated to exercise their civil, political and religious rights. Easy read information was provided to residents in relation to their rights. Residents were afforded the opportunity to vote. Residents were supported to access religious services and supports in line with their wishes.

Judgment:

Substantially 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:

Residents were facilitated to communicate in line with the centre-specific policy, reviewed in July 2015. Residents had diverse communication needs; some residents did not use verbal communication. The training matrix indicated that all staff had completed training in communication with residents.

A comprehensive assessment of each resident's individual communication needs was completed annually and this informed the plan of care developed for this area. In addition, some residents had access to specialist input from speech and language therapists, in line with their needs, who completed comprehensive communication assessments. Residents were facilitated to access assistive technology, aids and appliances to promote their full communication capabilities.

Visual aids and picture books were available to facilitate communication with residents, in line with the recommendations from the speech and language therapists.

A sample of personal plans was reviewed. The plans of care reviewed in relation to communication were comprehensive and outlined individual requirements, interventions and goals in relation to effective communication. Staff with whom inspectors spoke were knowledgeable in relation to each resident's individual communication needs. Inspectors observed that staff endeavoured to facilitate each resident to communicate effectively.

Judgment:

Compliant

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

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were supported to develop and maintain personal relationships and strong links with the wider community. Families were encouraged to be involved in the lives of residents.

Positive relationships between residents and family members were supported. Residents were supported to spend time with family including overnight trips at weekends and holidays. Residents were facilitated to keep in regular contact with family through telephone calls and family members were made welcome when visiting. There were adequate facilities for each resident to receive visitors and a number of areas were available if residents wished to meet visitors in private.

Staff stated and inspectors saw that families were kept informed of residents' well being on an ongoing basis. Records confirmed that families and residents attended personal planning meetings and reviews in accordance with the wishes of the resident.

There was policy in relation to visitors and the policy had been reviewed in June 2014. The policy outlined that visitors were 'valued and supported in line with the wishes of individual residents'.

Residents were supported to participate in a range of activities in the local and wider community including meals out, swimming, Special Olympics training and events, basketball, walking, horse riding and adult education classes. The residents were active members of the residents' association within the housing development and took part in annual social events and 'spring cleaning' in the neighbourhood. Residents were encouraged to shop, dine out and use services such as public transport locally.

Judgment:

Compliant

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):

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

Findings:

The policy on admissions, transfers and discharge of residents, which had been reviewed in October 2015, was made available. The policy outlined the transparent criteria for admission and took account of the need to protect residents from abuse by their peers. Residents' admissions were seen to be in line with the statement of purpose.

A written contract was in place which dealt with the support, care and welfare of the resident in the centre and included details of the services to be provided. The fees and additional charges were included.

Judgment:

Compliant

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:

A judgment of major non compliance in relation to Outcome 05: Social Care Needs was made at the previous inspection as the documentation and its usage did not demonstrate adherence to the regulations in terms of multidisciplinary assessment, implementation and review of personal plans. Inspectors noted that a cohesive personal planning process had been implemented. However, some areas required further improvement including the review of the personal plan, maintenance of an up to date hospital transfer document and the setting of specific goals to ensure the personal

development of all residents.

A sample of residents' plans was reviewed. An assessment of the health, personal, social care and support needs of the resident was completed annually and the information recorded as part of the assessment was individualised and person centred. The assessment formed the basis of an individual plan of care. A plan of care had been developed for each resident. The plan of care outlined residents' needs in many areas including communication, comprehension and decision making, eating and drinking, mobility, personal care, safe environment, sensory needs, spirituality and relationships. The resident and representatives were consulted with and participated in the development of the plan of care.

Goals and objectives were clearly outlined. There was evidence of resident involvement in agreeing/setting these goals. There was also evidence that individual goals were achieved. The goals outlined were based on each resident's assessed needs and their wishes including attending specific social events, a trip to the spa, breaks away, cookery classes, participating in a new sport, building family links and building a 'men's shed'. A goal tracking template was used to identify the resources required, steps need to plan, any obstacles encountered and the completion of goals. The person responsible for supporting the resident in pursuing these goals and the timeframe for completion was not clearly identified for the four plans reviewed. The lack of definite goals could lead to residents not maximising their personal development.

Staff and the person in charge outlined that the plan of care was subject to a review on an annual basis or more frequently if circumstances change. There was evidence that the review was carried out with the maximum participation of the resident. The review did assess the effectiveness of the plan and reviewed the goals/aspirations that had been identified. However, inspectors saw that one plan of care had not been reviewed and updated where a resident had been diagnosed on 09 June 2016 with a condition that could have a potentially major impact on quality of life and independence. This was discussed with the person in charge and the house manager who outlined that a review meeting was arranged.

In relation to the development of health care plans for residents, inspectors noted that plans of care had been developed in line with many residents' individual health care needs such as diabetes, epilepsy, cardiac needs, mental health, nutrition and mobility. However, inspectors noted that plans of care had not been developed for each resident's assessed health care needs. A cardiac needs plan of care had not been developed for a resident who had an assessed need in this area. A plan of care had not been developed for a resident to capture the recommendations made following the most recent bone density scan.

There was evidence of multi-disciplinary team involvement for all residents, in line with their needs, including psychiatry, speech and language therapy, general practitioner (GP), optical, audiology and psychology services. However, the review of the plan of care was not multidisciplinary in all plans of care seen during inspection.

Changes in circumstances and new developments were included in the personal plan and amendments were made as appropriate. However, residents reported that their

personal plan had not been made available in an accessible format in line with their needs.

A booklet ('hospital passport') was available for staff to record relevant and important information in the event of a resident being transferred to hospital. The hospital passport was completed in advance and contained comprehensive information in relation to the needs of the resident including communication, personal care and healthcare. However, the hospital passport was not accurate in some cases. For a resident who did not communicate verbally, the hospital passport indicated that the resident used few words to communicate. The family contact details were out of date for one resident. Some areas of another hospital passport were not complete in relation to pain management and nutrition.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The design and layout of the centre was in line with the centre's statement of purpose and met residents' individual and collective needs in a homely and comfortable way. However, there were some areas of maintenance that required attention.

The centre comprised two adjoining domestic two-storey houses located in a mature housing development. The centre was located in the suburbs of a large town close to local amenities and transport links.

Service Unit A contained four bedrooms; one of the bedrooms was located on the ground floor and three bedrooms were located on the first floor. The bedroom on the ground floor was for staff use and doubled up as office space. Adequate sanitary facilities were provided with en-suite shower facilities in all bedrooms, a bathroom on the first floor and additional toilet facilities on the ground floor.

Service Unit B also contained three bedrooms; one of the bedrooms was located on the ground floor and two bedrooms were located on the first floor. The bedroom on the ground floor was vacant at the time of the inspection. Adequate sanitary facilities were

provided with en-suite facilities in all bedrooms, a bathroom on the first floor and additional toilet facilities on the ground floor.

There was adequate private and communal space for residents. Bedrooms were personalised with the resident's choice of soft furnishings, photographs of family and friends and personal memorabilia. Ample storage space was provided for residents' personal use. Apart from the residents' own bedrooms, there were options for residents to spend time alone if they wished with a large sitting room and kitchen/dining area provided in both premises. All rooms were of a suitable size and layout for the needs of residents.

The centre was suitably decorated throughout. The residents had input into the décor of the centre and each area reflected the residents who resided there. There was suitable heating, lighting and ventilation and the centre was free from major hazards. There were suitable and sufficient furnishings, fixtures and fittings. Suitable adaptations such as grab rails were provided where appropriate. However, inspectors noted that some aspects required upgrade and maintenance. For example, the flooring on the ground floor in Service Unit A was scuffed and damaged in a number of areas. The door to the en-suite shower room in the vacant bedroom in Service Unit A was damaged.

Inspectors noted that there was a clear system of regular cleaning in place in the centre. A comprehensive cleaning schedule was in place. Staff reported that adequate cleaning equipment was provided. Many areas of the centre were visibly clean. However, gaps were noted between equipment in both utility rooms that would not promote effective cleaning. In addition, the storage space for cleaning equipment including mops in the utility room of Service Unit B was limited and could lead to cross contamination.

Each premises had a separate kitchen that was fitted with appropriate cooking facilities and equipment. Adequate laundry facilities were provided and residents were supported to launder their own clothes if they so wish. A contract was in place for the disposal of waste.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

There was a health and safety statement in place which outlined general aims and

objectives in relation to health and safety within the centre. The health and safety statement was augmented by a risk management policy, last reviewed in July 2015. The risk management policy had been updated since the last inspection to include the process for reporting incidents. The risk management policy outlined broad safety statements, the procedures for recording, reporting and investigation of accidents, a range of centre-specific risk assessments, an assessment of each risk and the controls identified as necessary to reduce each risk.

The risk register was reviewed by an inspector who saw that there was a system to identify and review hazards on an ongoing basis. The risks identified specifically in the regulations were included in the risk register. There was evidence that risk assessments had been implemented in practice and were kept under continual review.

A comprehensive emergency plan was in place, dated March 2014, which covered events such as natural disasters and utility failure. Provision was made to cover an event where the centre may be uninhabitable.

An inspector reviewed a sample of incident forms and saw that accidents and incidents were identified, reported on an incident form and there were arrangements in place for investigating and learning from accidents. The inspector noted that the improvements identified were implemented in a timely fashion. Incident forms were reviewed by the service manager in a timely manner.

Suitable fire safety equipment was provided throughout the centre. Fire safety equipment was to be serviced on an annual basis, most recently in October 2015. There was an adequate means of escape. Fire exits were unobstructed. The clear procedure for safe evacuation in event of fire was displayed in a number of areas. However, inspectors noted that inadequate measures were in place to contain fire as fire resistant doors were not installed in the centre. Due to the potential catastrophic impact of a fire, this outcome was judged to be at a level of major non-compliance. The provider was required to provide a report from a suitably competent person in relation to the fire safety measures in place in the centre

The fire panel and emergency lighting was serviced on a quarterly basis, most recently in July 2016. Records of daily and monthly fire checks were kept. These checks included inspection of the fire panel, escape routes, emergency lighting and evacuation procedure.

Staff demonstrated good knowledge in relation to fire safety and the procedure to follow in event of a fire. The training matrix confirmed that fire safety training and regular refresher training was mandatory for all staff. However, the training matrix indicated that six staff members required refresher fire safety training.

Fire drills took place at least every month. Residents and staff reported that they had all attended a recent fire drill. A detailed description of the fire drill, duration, participants and any issues identified was maintained for many fire drills. Inspectors saw that fire drills simulated both day and night time conditions and the associated staffing levels. However, for three fire drills since January 2016, the record did not record the number of residents present at the time of the drill.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents and had been updated every three months and in line with resident's changing needs.

Procedures were in place to for the prevention and control of infection. A comprehensive infection prevention and control policy was available, dated July 2015. The centre was visibly clean throughout. A colour coded cleaning system was in place to prevent cross contamination. Staff confirmed that personal protective equipment such as gloves and aprons were available. A robust procedure was in place for the safe handling of laundry and alginate bags were available for the safe handling and segregation of soiled laundry. The training matrix indicated that all staff members had completed infection prevention and control training.

The management of blood glucose monitoring equipment was in line with the safety alerts issued by HIQA. A risk assessment was in place for blood glucose monitoring. Each resident who required routine blood glucose monitoring had their own blood glucose monitor. The blood glucose monitor was clearly marked with the resident's details. Inspectors saw that the monitor was thoroughly cleaned after use and subsequently stored in an appropriate area.

The training matrix confirmed that moving and handling training and refresher training was mandatory for all staff. Safe moving and handling practices were observed.

Vehicles were available and records confirmed that the vehicles were roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

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:

Systems were in place to protect residents from being harmed or suffering abuse. A restraint-free environment was promoted. Supports were in place to ensure that residents were provided with emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges.

There was a policy and procedure in place in relation to the safeguarding of vulnerable adults, reviewed in January 2016. The policy identified the designated safeguarding officer and their deputy. The policy and procedure were comprehensive, evidence based and would effectively guide staff in the reporting and investigation of incidents, allegations or suspicions of abuse. The policy included a reporting pathway if the allegation was made against a member of the management team.

Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom inspectors spoke confirmed that they felt safe in the centre and that they knew who to talk to if they needed to report any concerns of abuse.

The provider and person in charge monitored the systems in place to protect residents and ensure that there are no barriers to staff or residents disclosing abuse. A robust recruitment and selection procedure was implemented, all staff received ongoing training in understanding abuse and staff stated that there was an open culture of reporting within the organisation.

Inspectors noted that there had been no incidents, allegations and suspicions of abuse since the last inspection. The person in charge and the person nominated on behalf of the provider outlined the steps that would be taken to ensure that any incident, allegation or suspicion of abuse was appropriately and comprehensively recorded, investigated and responded to in line with the centre's policy, national guidance and legislation.

A policy was in place to support residents with behaviour that challenges, reviewed in May 2014. The policy was comprehensive and focussed on understanding the function of the behaviour, responding and communicating appropriately and identifying triggers for the behaviour. Training records confirmed that training was provided to staff in the management of behaviour that is challenging including de-escalation and intervention techniques.

An inspector reviewed a selection of plans to support residents with behaviour that challenges and spoke with staff. Residents and their representatives were involved in discussions and reviews that had been arranged to support residents to manage their own behaviour. Specialist input had been sought and clear strategies were in place to support residents to manage their own behaviour and staff were able to describe the strategies in use. Protocols were in place and evidence based tools were used to validate that the strategies outlined were effective.

The policy in relation to restrictive practices was made available. The policy had been reviewed in July 2014, was comprehensive and was in line with evidence-based practice.

Staff were knowledgeable in relation to the policy and outlined that restraint was not in use in the centre at the time of the inspection.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

A comprehensive record of all incidents was maintained. Notifications to HIQA were made in line with the requirements of the regulations.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

There was a policy in place on access to education, training and development which had been reviewed in April 2015. Residents outlined that their education, training and development needs were met through attending a day service run by the organisation locally on week days. A number of day services were available to residents in line with their needs. Some residents travelled independently by public transport to their day service and others travelled on transport provided by the organisation. Some residents outlined that they had paid employment in local businesses or establishments run by the organisation.

An assessment of resident's educational, training and employment goals was undertaken as part of the comprehensive assessment. The assessment tool gathered information in relation to education history, current training/employment, literacy, time recognition and numeracy. The assessment formed the development of a plan of care. The assessment and plan of care were seen to be comprehensively completed for many residents. However, for one resident, areas of the assessment were left blank including numeracy, literacy, time recognition and independence. A plan of care in relation to this resident's education, training and employment goals had not been developed.

Staff with whom the inspectors spoke outlined that the assessment and day service provision was reviewed annually or when circumstances change. However, inspectors noted that the assessment and day service provision had not been reviewed for one resident. A resident had articulated a wish on 12 February 2016 to take a day or two off from the day service each week. This wish was articulated again at the residents' meeting in March 2016, May 2016 and June 2016. The assessment in relation to this resident's educational, training and employment goals had last been reviewed in June 2015 and no change had been made to the resident's day service.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Residents were supported on an individual basis to achieve and enjoy best possible health. However, improvements were required in relation to the integration of specialist recommendations into plans of care, follow up on these recommendations, the documentation of each resident's wishes in relation to care and support during times of illness and access to specialist services.

Residents' healthcare needs were met through timely access to health care services and appropriate treatment and therapies. A medical practitioner of their choice was available to each resident and an "out of hours" service was available if required. Access to a medical practitioner was facilitated regularly. There was clear evidence that there treatment was recommended and agreed by residents, this treatment was facilitated. Residents' right to refuse medical treatment was respected.

Where referrals were made to specialist services or consultants, staff supported residents to attend appointments. In line with their needs, residents had ongoing access to allied healthcare professionals including psychiatry, audiology, dental, dietetics, optical and chiropody. However, inspectors saw that there was a gap in relation to psychology support across the service. A referral had been made for one resident for possible memory loss in May 2015 and a subsequent referral had been made for this resident in January 2016. Staff confirmed that the referral was still outstanding at the time of the inspection.

Staff with whom inspectors spoke were conversant in relation to the individual recommendations made by allied healthcare professionals. Inspectors observed that the recommendations were implemented. However, inspectors saw a number of examples where recommendations from allied healthcare professionals had not been integrated into plans of care. The recommendations from the speech and language therapist were not integrated into two residents' plans of care. The recommendations from the optician were not integrated into two resident's plans of care. It was not clear if one of these recommendations which included a referral to the general practitioner due to a possible cataract had been followed through. This was outlined to the person in charge and person nominated on behalf of the provider who agreed to look into this.

The end of life policy was made available which described the procedure to be followed in the event of a sudden or unexpected death. A comprehensive and sensitive discussion had taken place with residents and their representatives to residents' views in relation to loss, death, dying and end of life. A plan of care for end of life was developed based on this discussion. However, much of the information contained in the plan of care related to care after death. Staff confirmed that an individualised plan of care had not been developed in relation to care at times of illness for each resident. Therefore, information would not be available to guide staff in meeting all residents' needs whilst respecting their dignity, autonomy, rights and wishes.

The management of epilepsy was in line with evidence-based practice. Residents were supported to attend regular reviews in relation to epilepsy management. Staff were conversant in the management of epilepsy and seizures. Where rescue medicine was prescribed, inspectors that the medicine was available at all times and staff had been trained in the administration of this medicine. Individualised epilepsy care plans had been developed for all residents with a diagnosis of epilepsy which outlined type of epilepsy, description of seizures, identified triggers, medicines prescribed, frequency of review, 'rescue' medicines prescribed and management of seizures.

For residents with diabetes, a comprehensive and individualised plan of care had been developed in line with evidence based and contemporary practice. Residents were supported to attend reviews at a multi-disciplinary diabetes clinic. Education had been provided to residents and staff in relation to diabetes, individualised management, dietary modifications and exercise. Staff were conversant in the day to day management of diabetes, relevant dietary modifications and each resident's individual plan in relation to low/high blood glucose. Blood glucose was monitored in line with specialist recommendations. Residents were supported to join a national group which supports people with diabetes.

Residents were encouraged and enabled to make healthy living choices in relation to exercise, weight control and healthy eating. Residents were encouraged to be active through swimming, walking and participating in team sports. Staff with whom inspectors spoke outlined that residents were supported to access a clinical nurse specialist in nutrition, a dietician or speech and language therapist in line with their needs. However, it was noted that a resident had experienced an unexplained weight loss of 6.5% since March 2016 and a referral had not been made to the clinical nurse specialist or dietician in line with the centre's policy.

Residents were encouraged to be involved in the preparation and cooking each meal. Residents reported that a choice was offered for each meal. The meals outlined by staff and residents were nutritious and varied. A healthy choice of cereals, hot beverages, toast and yoghurt were available for breakfast. On first day of the inspection, freshly prepared meatballs in a tomato sauce was chosen by all residents and was observed to be enjoyed by all.

There were ample supplies and choice of fresh food available for the preparation of meals. Outside of set mealtimes, residents had access to a selection of refreshments and snacks and residents were encouraged to prepare their own refreshments and snacks. There was adequate provision for residents to store food in hygienic conditions.

Residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents' needs was available in an easy read format.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland.

There was a centre-specific medicines management policy and had been reviewed in July 2015. The policy detailed the procedures for safe ordering, prescribing, storing,

administration and disposal of medicines. Staff demonstrated an understanding of medicines management and adherence to guidelines and regulatory requirements. The training matrix indicated that training had been provided to all staff in relation to medicines management.

Inspectors noted that medicines were stored securely throughout. Staff stated and inspectors confirmed that medicines requiring refrigeration or additional controls were not in use at the time of the inspection. A guideline had been put in place since the last inspection to ensure that suitable storage would be available if medicines requiring refrigeration were prescribed for residents.

A sample of medication prescription and administration records was reviewed by an inspection. Medication prescriptions records contained the required information. Medication administration records identified the medicines on the prescription and allowed space to record comments on withholding or refusing medicines.

The practice of transcription was in line with guidance issued by An Bord Altranais agus Cnáimhseachais. The signature of the transcribing nurse and the signature of the second nurse who independently checks the transcribed record were present and the records were co-signed by the prescriber.

An individualised medicines management plan of care had been developed for each resident to guide staff in relation to the administration of medicines to each resident and the associated monitoring of medicines for effectiveness or side effects. Staff with whom inspectors spoke were knowledgeable in relation to each individual plan of care. However, the plans of care for residents who were prescribed medicines with specific monitoring or administration requirements were not adequate to ensure the safe management of these medicines. For a resident who was prescribed warfarin, the specific dietary guidelines and brand of warfarin to be administered were not outlined. For a resident who was prescribed a once weekly medicine with specific requirements in relation to administration to prevent side effects, these requirements were not outlined in the plan of care.

There was evidence that residents were offered the opportunity to take responsibility for their own medicines. Staff with whom inspectors spoke confirmed that no residents were self-administering medicines at the time of inspection. A comprehensive and individualised risk assessment was available which took into account cognition, communication, reception and dexterity.

Staff outlined the manner in which medicines which were out of date or dispensed to a resident but were no longer needed are stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

Staff confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the prescription records. A system was in place for reviewing and monitoring safe medicines management practices. The results of the most recent medicines management audit in July 2016 were made available.

Inspectors confirmed that actions had been completed.

When residents left the centre for holidays or days out, a documented record was maintained of the quantity and medicines given to the resident and/or their representative. This record was signed by staff and the resident and/or their representative. A similar record was maintained when the resident returned to the centre and the quantities were reconciled by staff.

A sample of medication incident forms were reviewed and inspectors saw that errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. Learning from incidents was clearly documented and preventative actions were seen to be implemented.

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:

The statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. The statement of purpose was made available to residents and their representatives.

The statement of purpose contained all of the information required and inspectors found that the Statement of Purpose was clearly implemented in practice. The statement of purpose had been last reviewed in July 2016.

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):

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

Findings:

There was evidence of a defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision.

The person in charge was employed full time by the organisation and had many years' experience supporting people with disabilities. At the previous inspection, it was not clear whether the person in charge met the requirements of the regulations in terms of holding an appropriate qualification for the role of person in charge. Following the previous inspection, it had been identified by the provider that it was necessary for the person in charge to undertake further training in a third level institution. The person in charge confirmed that he was undertaking the further training at the time of the inspection.

The person in charge was also appointed as the person in charge in three other centres. A house manager was appointed in the centre to ensure the effective governance, operational management and administration of the centre. The house manager demonstrated an in-depth knowledge of the residents, their achievements, likes/dislikes and their support needs. Residents were observed to be comfortable and familiar with the house manager. Residents were very complimentary of the house manager and the support she provided. Staff confirmed that the house manager was approachable and supportive. The house manager confirmed that the person in charge was accessible at all times. A good working relationship was observed between the person in charge and the house manager.

Two clinical nurse managers were appointed to provide clinical oversight to the centres. The clinical nurse manager responsible for this centre was also responsible for five other centres. As outlined in Outcome 11, residents required support in relation to their healthcare needs which included epilepsy, diabetes and dementia. Some residents required daily interventions such as modification of food and fluid and monitoring of blood sugar levels. Inspectors noted that improvements were required in relation to the integration of specialist recommendations into plans of care, follow up on these recommendations, the documentation of each resident's wishes in relation to care and support during times of illness and access to specialist services. Of note, a resident had experienced an unexplained weight loss of 6.5% since March 2016 and a referral had not been made to the clinical nurse specialist or dietician in line with the centre's policy. The clinical nurse manager acknowledged the deficits in relation to the plans of care.

Inspectors concluded that additional clinical oversight was required due to the lack of consistency in relation to health care plans of care and response to changes in clinical status.

There were established regular weekly management meetings attended by the persons in charge in all centres, clinical nurse managers and the person nominated on behalf of the provider.

The provider had arranged for an unannounced visit to the centre in the last six months to assess quality and safety of the care and support in the centre. The most recent unannounced visit which had been completed in January 2016. There was evidence of progress against the action plan.

The annual review of the quality and safety of care in the centre was made available. The review was comprehensive and based on the standards and regulations. Areas for improvement were identified and actions completed in a timely fashion. There was evidence of ongoing quality assurance and improvement through regular audits in key areas such as infection prevention and control, fire safety, medicines management and risk management. An annual survey of residents/representatives had been completed in October 2015. The audits identified areas for improvement and audit recommendations. Improvements were brought about as a result of learning from audits.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

There had been no periods where the person in charge was absent from the centre for 28 days or more since the commencement of the Regulations and there had been no change to the person in charge. The provider was aware of the obligation to inform the Chief Inspector if there is any proposed absence of the person in charge and the arrangements to cover for the absence. Inspectors were satisfied that suitable arrangements were in place for the management of the designated centre in the absence of the person in charge. The home manager was nominated as the person responsible for the management of the centre in the absence of the person in charge with support from two clinical nurse managers.

<p>Judgment: Compliant</p>

<p>Outcome 16: Use of Resources <i>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</i></p>
<p>Theme: Use of Resources</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The centre was adequately resourced to ensure the effective safe and effective delivery of care and support in accordance with the Statement of Purpose. Sufficient resources were available to support residents to achieve the goals. Inspectors observed that there was sufficient transparency in planning and deployment of resources in the centre. The facilities and services available in the designated centre reflected the Statement of Purpose</p>
<p>Judgment: Compliant</p>

<p>Outcome 17: Workforce <i>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.</i></p>
<p>Theme: Responsive Workforce</p>
<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: There was a planned and actual staff roster in place which showed the staff on duty during the day and the sleepover staff on duty at night. Staffing levels had been reviewed since the last inspection and it was reported that adequate staffing levels were</p>

available to ensure that residents were facilitated to attend social outings or access the community in line with their wishes. Based on observations, a review of the roster and these inspection findings, inspectors was satisfied that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs of the residents. The roster indicated that a regular team supported residents and this provided continuity of care and support.

A sample of staff files was examined and contained the required elements. There was evidence of effective recruitment and induction procedures; in line with the centre-specific policy, last reviewed in June 2014.

Staff were observed to be supervised appropriate to their role on a formal and informal basis. Regular staff meetings were held and items discussed included policies and procedures, audit results, training, arrangements for residents' finances, activities, advocacy, risk management, complaints, staffing levels and infection control.

Staff were able to articulate clearly the management structure and reporting relationships. Copies of both the regulations and the standards had been made available to staff and staff spoken with demonstrated adequate knowledge of these documents.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge. Training had been completed in food safety by all staff since the last inspection. However, the training matrix indicated that dementia training had not been completed by staff in line with residents' needs. In addition, refresher training in manual handling was outstanding for four staff members.

The house manager and person in charge confirmed that volunteers were not attending the centre at the time of the inspection.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

The records listed in Schedules 3 and 4 of the regulations were maintained in the centre.

All of the key policies as listed in Schedule 5 of the regulations were in place. These policies were stored in the centre and were easily accessible for staff. A process was in place to ensure that policies and procedures were reviewed and updated to reflect best practice and at intervals not exceeding three years. However, the medicines management policy did not contain information to guide staff on the safe administration of a number of dosage forms/routes including topical, inhalers, nebulisers, eye/ear/nasal drops and injections. Inspectors noted that some residents were prescribed topical preparations at the time of the inspection.

Records were kept securely, were easily accessible and were kept for the required period of time. A system was in place to store residents' records were stored securely. The system in place for maintaining files and records was very well organised.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the regulations.

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:

Louisa Power
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 report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
Centre ID:	OSV-0003947
Date of Inspection:	14 and 15 July 2016
Date of response:	20 December 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Locks were not provided on the doors of all toilets and sanitary facilities to facilitate all residents to adequately maintain their privacy and dignity

The plan of care for one resident did not reflect the check list in relation to supports

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

required for some intimate care tasks.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

All locks have been places on doors. 13/09/2016

The plan of care for one service user has been updated and reflects the check list being completed.

Proposed Timescale: 01/08/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

The person responsible for supporting the resident in pursuing these goals and the timeframe for completion was not clearly identified for the four plans reviewed.

2. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

A keyworker has been identified for each individual service user. Timeframes have been agreed. Each goal has been broken down into easy steps and these are tracked and dated on completion.

Proposed Timescale: 01/08/2016

Theme: Effective Services

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

Plans of care had not been developed for each resident's assessed health care needs.

3. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects

the resident's assessed needs.

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

A plan of care has been developed for each service user. A specific plan of care one service user with Dementia has been commenced. The service user had a psychiatry appointment on the 11/07/2016 and 18/08/2016. An Occupational Therapist environmental assessment on 08/07/2016. The service user has had a CT scan completed on 09/11/2016. The service user is meeting with the Consultant Psychiatrist on the 22/12/2016 for a consensus meeting to confirm diagnosis.

Proposed Timescale: 30/12/2016

Theme: Effective Services

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

Plans of care were not reviewed and updated when circumstances change.

4. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

All plans of care have been reviewed and updated by PIC and CNM3. A cardiac plan of care has been completed on a service user with a heart murmur.

Proposed Timescale: 01/08/2016

Theme: Effective Services

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

The review of the plan of care was not multidisciplinary in all plans of care seen during inspection

5. Action Required:

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

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

All service users within this designated centre have access to the full range of MDT supports. The PIC will ensure all MDT goals are in SMART format, specific, measurable, achievable, realistic and timed. The PIC will audit these on a three monthly basis. Any recommendations or official reports from members of the MDT will be incorporated into a specific part of the Care Plan. Interviews for a Psychologist took place in early December. There was a successful candidate. They are currently being processed by HR.

Proposed Timescale: 13/03/2017

Theme: Effective Services

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

Personal plans were not made available to residents in an accessible format.

6. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

All PCP's will be presented to each service user in an accessible format. This will be done by picture format and an easy to read version. One service user uses assistive technology to view their PCP.

Proposed Timescale: 31/12/2016

Theme: Effective Services

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

The hospital passport was not accurate in some cases.

7. Action Required:

Under Regulation 25 (1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre to the person taking responsibility for the care, support and wellbeing of the resident at the receiving designated centre, hospital or other place.

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

All hospital passports have been completed and updated.

Proposed Timescale: 01/08/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Some aspects required upgrade and maintenance.

8. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

Costings have been submitted for new flooring on the ground floor. Once these are submitted the required works will be completed.

Proposed Timescale: 19/02/2017**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Gaps were noted between equipment in both utility rooms that would not promote effective cleaning.

9. Action Required:

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

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

All gaps between equipment in the utility room have been repaired

Proposed Timescale: 07/11/2016**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The storage space for cleaning equipment including mops in the utility room of Service Unit B was limited and could lead to cross contamination

10. Action Required:

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

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

Costings have been submitted for a new storage cupboard to be built in Unit B. Once these are submitted the required works will be completed.

Proposed Timescale: 19/02/2017**Outcome 07: Health and Safety and Risk Management****Theme:** Effective Services

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

Inadequate measures were in place to contain fire as fire resistant doors were not installed in the centre.

11. 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:

A report completed by a fire consultant was submitted to HIQA on the 19/10/2016. The works on the locks have been completed. The fire alarm and emergency lighting has been completed. All staff within the centre has received fire training and evacuation plans are posted in appropriate areas. The centre has all the required certification for electrical, fire alarm and emergency lightening. There is a spark guard for the open fire. The mobility status for all service users has been updated. The works on the fire doors remain outstanding as the organisation awaits funding.

Proposed Timescale: 31/03/2017

Theme: Effective Services

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

The training matrix indicated that six staff members required refresher fire safety training.

12. Action Required:

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

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

The remaining staff completed the fire training on the 09/09/2016

Proposed Timescale: 09/09/2016

Theme: Effective Services

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

Fire drill records did not always record the number of residents present at the time of the drill.

13. Action Required:

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

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

A new fire drill records form which identifies the number of service users involved / present in a fire drill as per 2016 fire policy is in place

Proposed Timescale: 01/08/2016

Outcome 10. General Welfare and Development

Theme: Health and Development

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

A resident's attendance at day service had not been reviewed despite repeated requests from the resident.

Areas of the assessment were left blank and a plan of care had not been developed for one resident in relation to education, training and employment.

14. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

An assessment of needs was completed on the service user. The service user has agreed to take one day off from their day service each week commencing January 2017. Staffing levels reviewed to facilitate same.

Proposed Timescale: 09/01/2017

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:

Recommendations from allied healthcare professionals had not been integrated into plans of care.

15. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

All recommendations from allied healthcare professionals had been integrated into plans of care for each service users.

Proposed Timescale: 01/10/2016

Theme: Health and Development

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

It was not clear if a recommendation from an optician which included a referral to the general practitioner due to a possible cataract had been followed through.

16. Action Required:

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

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

A recommendation from the Optician was reviewed by the GP. The service user has another appointment with the optician in May 2017

Proposed Timescale: 14/12/2016

Theme: Health and Development

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

An individualised plan of care had not been developed in relation to care at times of illness for each resident.

17. Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

An individualised plan of care at time of illness for each service user has been completed.

Proposed Timescale: 13/12/2016

Theme: Health and Development

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

A referral had been made for one resident to psychology in May 2015 and a subsequent referral had been made for this resident in January 2016. Staff confirmed that the

referral was still outstanding at the time of the inspection.

A resident had experienced an unexplained weight loss of 6.5% since March 2016 and a referral had not been made to the clinical nurse specialist or dietician in line with the centre's policy

18. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

Interviews for a Psychologist took place in early December 2016. There was a successful candidate. They are currently being processed by HR. In relation to the individual resident, they have had a dementia assessment on 09/06/2016, Psychiatrist review on 11/07/2016, 18/08/2016 and a consensus on 22/12/2016.

The service user who had weight loss was on a weight management plan. Speech and language therapist has been involved in their care. They are to be reviewed by the dietician on 12/01/2017

Proposed Timescale: 12/01/2017

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:

Plans of care for residents who were prescribed medicines with specific monitoring or administration requirements were not adequate.

19. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

A specific plan of care has been devised and implemented for a service user who is prescribed Warfarin medication. The plan of care reflects the dietary guidelines and side effects of the medication. PIC and CNM3 review all plans of care as required.

Proposed Timescale: 01/09/2016

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 person in charge was undertaking further training to meet the regulatory requirements.

20. 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:

The PIC is currently in year two of a part time four year BA degree in social care. They will complete the course in May 2019

Proposed Timescale: 01/05/2019

Theme: Leadership, Governance and Management

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

Additional clinical oversight was required due to the lack of consistency in relation to health care plans of care.

21. Action Required:

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

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

The PIC is currently over two centres now. They have clinical support from the CNM3 and nominee provider. The PIC links with the members of the MDT and they update all plans of care as required. The Quality and Risk officer completed an audit on 05/10/2016

There are Governance meetings with all PIC's the Nominee Provider and CNM3's.

Proposed Timescale: 05/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Dementia training had not been completed by staff in line with residents' needs.

Refresher training in manual handling was outstanding for four staff members.

22. 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 training has been completed by staff

Manual Handling training was completed on 17/11/2016

Dementia training was completed 18/07/2016

Proposed Timescale: 17/11/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

The medicines management policy did not contain information to guide staff on the safe administration of a number of dosage forms/routes including topical, inhalers, nebulisers, eye/ear/nasal drops and injections.

23. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The medicines management policy has been updated to contain information to guide staff on the safe administration of a number of dosage forms/routes including topical, inhalers, nebulisers, eye/ear/nasal drops and injections. This information is in Appendix 3 of the new policy.

Proposed Timescale: 31/12/2016