Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Centre 3 - Aras Attracta
Centre ID:	OSV-0004911
Centre county:	Mayo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Suzanne Keenan
Lead inspector:	Catherine Glynn
Support inspector(s):	Christopher Regan-Rushe; Jackie Warren
Type of inspection	Announced
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
16 May 2017 09:30	16 May 2017 19:30
17 May 2017 09:00	17 May 2017 19:00
18 May 2017 08:30	18 May 2017 14:30

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 inspection:
This was an announced inspection which was completed in order to inform a decision on the registration of the centre.

Over the last three years, this centre has been subject to an increased regulatory monitoring programme, due to significant concerns relating to the safety and wellbeing of residents who lived in the centre at that time. In response to these concerns an increased regulatory monitoring programme was developed by the

Authority for each of the three centres located on the Aras Attracta campus.

Over the course of the monitoring programme, inspections have been completed to monitor the effectiveness of the actions the provider has taken to bring the centres into compliance with the regulations and standards.

During this inspection, inspectors also reviewed the actions the provider had said they would take following the centre's previous inspection, conducted on 18 and 19 of October 2016.

How we gathered our evidence:
During the inspection, the inspectors met with 17 residents both as a group and individually, where appropriate. Inspectors also met with 13 staff including the person in charge, the transition coordinator, social care leaders and ancillary staff. As part of the inspection, inspectors also met one family member.

Inspectors also observed staff interactions with residents and reviewed documentation including residents' personal plans, health records, risk assessments, policies, procedures and staff files.

Description:
The provider had produced a document called the statement of purpose, as required by the regulations. Inspectors found that the service provided was not accurately described in that document, in relation to operational aspects of the service.

The centre comprised of six single storey bungalow dwellings based on a large campus setting. This campus was located close to a regional town in County Mayo, with easy access to local amenities and shops.

Overall judgment of our findings:
Inspectors found that the provider's governance and management systems in the centre were ineffective and had not ensured that failings identified from the previous inspection had been addressed. Inspectors found that 18 of the 21 of the provider's actions identified in response to the previous inspection had not been completed. This meant that while the provider had maintained some aspects of the improvements found during the previous inspection, there continued to be significant variation in the provision and quality of service to residents in different bungalows within this centre.

Of the 18 outcomes inspected,10 were found to be in major non-compliance, including key areas such as safeguarding, risk management and social care needs for residents. Five outcomes were in moderate non-compliance, one outcome was in substantial compliance and two were in compliance with the regulations and standards.

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 of this report.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that there were arrangements for consulting with residents and for ensuring the privacy and dignity of residents in the centre. However, there continued to be institutional arrangements in relation to meals and laundry in three of the six houses. After the inspection in October 2016, the provider had stated the actions they would take to improve this, and inspectors found that those actions had not been implemented. Inspectors also found that further improvements were required in responding to complaints.

Inspectors found that residents were consulted through house meetings about how they would like to live their lives. House meetings took place weekly in each house and minutes showed that residents had discussed shopping, plans for the meals, outings and safeguarding.

Residents also had access to a campus based residents’ committee, and there was access to an advocacy service, details of which were displayed for residents. Residents confirmed that visitors were welcome to visit them in the centre. Visitor rooms were available in all houses. There were arrangements to promote residents' privacy and dignity and each resident had a private bedroom. Residents had access to keys to their rooms, and could lock their doors if they chose to.

Inspectors found that residents’ religious and civil rights were supported. Mass was celebrated in the centre campus weekly and all residents had the option to attend this. Staff also made arrangements to bring residents, who wished to attend, to Mass in the

local area at weekends. Residents who attended these told inspectors that they enjoyed them. During the inspection, inspectors saw residents walking in the grounds, either accompanied by staff, alone, or with other residents. Several residents went to various activities in the local area with staff, such as, shopping, to visit Knock Shrine and out for meals.

However, inspectors found that there were two different models of care in operation in the centre and the quality of life for residents was dependent on which bungalow they lived in. In three of the houses, residents were involved in important aspects of their day to day lives such as meal planning, grocery shopping and meal preparation, which they told inspectors that they enjoyed. In the other three houses residents did not have adequate opportunities to exercise choice around meals and domestic activities. Although there were suitably equipped kitchens in all the houses, residents in these three houses did not have the option of preparing their meals, if they wished to with the exception of occasional evening teas being prepared. Residents in these three houses had most of their meals supplied by a central kitchen, and were either eaten in a large campus dining room located in the main building, or delivered to residents' houses.

While there had been improvements for some residents in relation to laundry arrangements, this was inconsistent. In some houses, residents did their own laundry with staff support. Residents proudly told inspectors about their care for their own clothing, and showed inspectors their bedrooms which had personalised linens and bed covers in accordance with each resident’s preferences. However, in the other houses, residents were not provided with the option of managing their own laundry and all laundry continued to be sent out to an external company. Inspectors found that in these houses residents did not have the option of using personal linens and bed coverings of their own choice.

Inspectors found that there had been improvements in the complaints process, but further improvements were required. Inspectors saw that details of how to make a complaint were displayed in the centre, and residents who spoke with inspectors were clear on how to do this. All complaints were now recorded and investigated in line with the provider's policy with the actions taken and outcomes clearly documented.

However, while each complainant was written to following the investigation with the details of how the complaint had been resolved, these letters did not include details of the appeals process. In addition, inspectors found that the recording of some complaints did not include the outcome of the complaint and whether or not the complainant was satisfied.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
During the last inspection of the centre in October 2016, inspectors found that communication plans did not clearly outline residents' communication needs. On this inspection the inspector found that there had been improvements in three of the houses in the centre but that these improvements had not been implemented in the other three houses. Inspectors found that this impacted on some residents' opportunities to communicate to their full capabilities.

Since the last inspection communication passports had been developed for each resident. Supports and aids were in place to assist residents with aspects of their communication needs, although these were not consistent through all houses in the centre. For example, in three of the houses pictorial activity boards were in use. These were supported by picture boards which were used to show which staff and residents were in the houses. In addition, computer technology was being used to promote communication skills for some residents. However, in the remaining three houses, these interventions were not being used.

While communication passports had been developed for all residents and these were generally informative and user friendly, some did not provide sufficient detail of communication techniques specific to each resident to aid and support the development of effective communication.

Residents had access to information, such as televisions, radios, books, magazines, computerised devices, internet and some had their own mobile phones. Information regarding access to advocacy and complaints processes was made available to residents, and notices about local events, concerts and mass times were also displayed. In some houses visited by inspectors, meal options from the central kitchen were displayed to residents in a colourful pictorial format to assist them in making their choices.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Residents who lived in the centre were supported to maintain relationships with their families.

Residents' families and friends could visit at any time, and visits to residents' families were arranged and supported by staff as confirmed through discussion with residents and daily activity records.

Families were invited to attend and participate in residents' personal planning meetings. Many residents attended a variety of activities in the service on weekdays where they had the opportunity to meet and socialise with other people. These included going to the gym, playing pool, and attending art and crafts classes.

Some residents, who spoke with inspectors, spoke of going out to concerts, for meals, for outings, bowling and to the cinema. Some residents frequently visited the hairdressers, shops and country markets in local towns.

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

Findings:
Inspectors found that the provider and person in charge had not addressed the actions arising from the previous inspection and there continued to be no signed agreements in place for any resident. In addition, inspectors found that in January 2017 the provider had admitted a resident for respite and had inappropriately accommodated this resident by putting a bed in the residents' visitors room.

Inspectors found that while a revised contract was held in each resident's file these were not signed. However, the inspector noted that these documents had been provided to

the residents' representatives and relatives at the beginning of May.

Some residents told inspectors that they had made complaints about an admission to their home and that the provider had not looked into the complaint or responded to it. Inspectors reviewed the admissions to the centre and found that there had been a short-term admission of a resident since the last inspection. The resident had been moved into the visitors room in one of the houses and as a result, residents had their communal space reduced in the house without consultation. The provider had also breached their own statement of purpose and had exceeded the number of residents to be accommodated in that house.

Inspectors requested the dates of this admission and discharge from the provider. The provider failed to give this information to inspectors during the inspection. The inspector requested the provider to investigate this admission and provide a written report. This report confirmed that the admission had not been completed in line with the statement of purpose. The admission had also impacted on the communal space of other residents and the provider had failed to notify the Chief Inspector of the admission or make an amendment to the statement of purpose as required.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Inspectors found that there continued to be good social care practice in three of the houses, but that the arrangements in the other three houses had not improved since the previous inspection and continued to be inadequate. Inspectors found that some practices remained institutional in nature and reliant on task based or centralised and communal approaches to social care support. In addition, inspectors found that access to social engagement or community access continued to be limited. The provider and person in charge had not implemented their own action plan from the previous

inspection.

In three of the houses Inspectors found that the previous improvements made by the provider for residents to engage and participate in community activities and social events had been maintained. In these three houses, residents had opportunities to engage in meaningful day services and to access educational opportunities or have active employment, such as volunteering.
However, in the other three houses there continued to be a reliance on institutional practices to support residents on a daily basis. Inspectors found that task orientated and communal approaches, identified at the last inspection continued. In three of the houses the daily routine was not based on the wishes and aspirations of residents and was focussed on the completion of daily household chores and staff duties.. Inspectors found that the person in charge and provider had failed to address this issue in line with their own action plan.

Inspectors found that the provider had failed to ensure that the provision of support to residents was based on a comprehensive assessment. For example, in one house four residents were living together. Two of these residents had high support needs requiring 2-to-1 support. The remaining residents could not engage in their individual activities while this support was ongoing.
Furthermore, inspectors found that the provider had failed to suitably assess the compatibility of residents living together For example, in one house older residents with low to very high support needs were living with young, more active residents. Inspectors noted in this house that the younger residents individual social care support needs were not being met as staff were allocating the majority of their time caring for and supporting the older residents.

Inspectors reviewed a sample of six personal plans. The quality, content and detail of these plans varied significantly. Inspectors found an example of a resident's file containing confidential information about another resident’s personal plan. Inspectors also found that some personal plans had not been reviewed at least annually and that for one resident, who had experienced a significant change in their care and support needs, no annual review had been completed since January 2016.

Inspectors were informed that a regular multidisciplinary review process was in place to oversee the care and support of residents. However, these multi-disciplinary reviews did not always include the resident or their representative. Inspectors also found that the details of these discussions were not being recorded in the residents' files and were not being used to inform the residents' personal plans or the overall annual review. As a result, inspectors found that staff were not being provided with regular updates or guidance to ensure that the changes or revision to the residents' personal plans and support, agreed in the multi-disciplinary reviews, was being implemented as directed by relevant clinicians.

Inspectors found inconsistencies in the overall maintenance of residents’ personal plans. Regular monitoring of the implementation of these plans and the achievement of personal goals had not taken place. In addition, inspectors found examples of personal plans which had not been updated to include important information relating to changes in the level of care required, mobility issues and wishes expressed by the residents'

families. Inspectors also noted that the provider had failed to ensure that where reviews had been completed that the effectiveness of the personal plans was also reviewed.

In three of the houses, inspectors noted that there continued to be limited opportunity for residents to access the community effectively due to staff availability and transport issues. This meant that for these residents, activities were focused either in the house or in the immediate campus and not in line with the expressed wishes of the resident or their family.

There were active transition plans in place for some residents to support them to move to more appropriate, community based living arrangements. The inspectors found that a structured programme was in place to implement these plans. However, inspectors found that residents and staff were not fully aware of these plans or the timeframes for their completion. In addition, details of these transition plans were not included in the residents' overall personal plans as required by the regulations.

Residents in three of the houses had been offered a choice to hold a copy of their personal plan and goals agreed in their room or in an accessible file. However, inspectors found that personal plans were not provided in an accessible format for residents in the other houses.

Judgment:
Non Compliant - Major

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

Findings:
Inspectors found that the provider and person in charge had not addressed the actions arising from the previous inspection. There continued to be a lack of routine maintenance through the centre, resulting in a poor quality of living environment for residents.. Inspectors also found that there was no overarching system in place to monitor and oversee the progress of any requested repairs and no timeframes recorded for when these would be completed. In addition, access to appropriate bathroom facilities had not been addressed

Inspectors completed a walk around of all houses that were part of the designated centre. Staff highlighted various maintenance works that required completion. Inspectors found that the provider was not monitoring the state of the buildings or the response to maintenance issues. There was no central record kept of the work required throughout the designated centre which detailed the date the repairs were requested, the interim control measures, the actions required to rectify the repair and the timescale for its completion. Inspectors asked staff and the person in charge if they completed an environmental audit of their premises on a regular basis. Inspectors were advised that these were not being completed for the centre and that dilapidations identified in the centre were not being routinely risk assessed.

In some houses in the centre, the living environment had significant and ongoing dilapidations including:
- ceiling tiles were discoloured with evidence of water damage in resident areas
- hazardous debris on external paths and a gutter was damaged which was leaking onto pathways
- cupboard doors missing in some kitchen units
- noticeable damage on worktop counters in kitchens.

In addition, while work had commenced to improve two bathroom facilities, the inspectors found that these bathrooms were inaccessible for residents with no timescale for completion of the work which limited the number of bathroom facilities available to residents.

Overall, houses in the centre were in various states of repair which significantly impacted on the overall appearance and quality of the environment in the centre.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Inspectors found that the systems in place for the identification, recording, monitoring, review and management of risk within the centre were inadequate. Where risks had been identified, the provider had not taken sufficient action to ensure that these risks did not adversely impact on the quality of the service and the residents' care and support.

Inspectors found that the risk management policy did not contain critical components, as required by the regulations, which guide staff and managers on how to safely address risk in a concise and coordinated manner. Following the previous inspection, the provider set out four actions that they would implement in response to risk related issues. The provider had not completed any of their actions.

Inspectors found that the provider had not put the required fire precautions in place. Actions which the provider stated would be addressed from the previous inspection, including the installation of emergency lighting and fire doors had not commenced. Inspectors spoke with the person in charge about the installation of emergency lighting, which the provider stated would be completed by 9 May 2017. The person in charge stated that funding for the installation of emergency lighting had only been approved during the course of the inspection, There was no revised timeframe for when this work would commence. Inspectors noted that during a recent service of the fire systems, the engineer had documented the need for appropriate emergency lighting and fire doors throughout the designated centre. Inspectors found that the actions from a previous competent person's fire report had not been implemented in line with the recommended timeframes., The provider informed inspectors that a further fire risk report had recently been completed by a competent person. A copy of this report was requested by the inspectors for review but the provider was unable to provide it or to detail the recommendations made in the report.

Inspectors found that there were systems and measures in place to support the evacuation of residents from the centre and to promote their awareness of fire safety procedures. For example, fire drills were being completed as scheduled and evidence of learning from these was being recorded for each drill completed. Fire equipment was provided throughout the designated centre, which was being serviced on a regular basis. Inspectors found a record of this servicing was maintained in each bungalow. All residents had a personal emergency evacuation plan (PEEP) completed and this was available in their personal plan and in fire safety records held in each house. Residents and staff spoken with understood the supports required by residents and knew the procedures in place. All staff were found to have completed fire safety training. The inspectors saw that fire procedures and guidance were displayed throughout the designated centre.

The management, assessment and monitoring of risk was being completed throughout this centre. However, inspectors noted that there were gaps in the detection and control of hazards and risks. For example, staff had failed to appropriately risk rate a falls hazard posed by an external emergency escape route. In addition, the lack of sufficient staff to supervise residents with specific risks had not been appropriately identified.

Inspectors found that there were arrangements in place to manage other risks, but were concerned that there were large gaps in recording of incidents in the centre. The health and safety folders contained guidance on missing persons procedures and emergency plans in relation to power failure and flooding for the designated centre. The person in charge told inspectors that they attended an incident review group which supported the monitoring of incidents. However, inspectors noted that there were significant gaps in incident and accident records. The inspectors found that incident forms were not

available from March 2016 until April 2017 and when requested, the provider and person in charge were both unable to produce them.

Training records were reviewed and inspectors found that staff had not completed mandatory training in line with the organisations requirements. For example, staff had not completed all aspects of manual handling training as required, which increased the risk of harm to residents and to staff. In addition, hand hygiene training, as required by the provider's training plan, had not been completed by all staff working in the designated centre.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Inspectors identified improvements that were required to the provision of behaviour support, restraint assessment, safeguarding and the guidance on use of chemical restraint.

The person in charge was knowledgeable regarding her responsibilities in relation to adult protection, and was clear on how she would respond to any allegation or suspicion of abuse. There was a designated safeguarding officer who was based in the centre complex. Contact details for the designated officer were clearly displayed. Residents told inspectors that they were well supported by staff, felt safe living in the centre, and knew who to speak to if they had any concerns. Inspectors observed staff interacting with residents in a respectful and friendly manner.

There was a policy on the safeguarding of adults from abuse and a staff safeguarding training schedule. However, the person in charge had not ensured that all external workers contracted to the centre had been suitably trained in safeguarding. Although all staff employed directly by the provider had received safeguarding training, some housekeeping workers who had regular access to residents, contracted from an external agency, had not completed safeguarding training.

While there were procedures in place to protect residents from being harmed or abused, inspectors found that there was a lack of clarity around the number of active safeguarding plans in the centre. Safeguarding plans are an important part of ensuring that residents are protected from the risk of abuse, ensuring that staff are aware of the safeguarding risks for residents and in directing staff on how to best protect the residents from safeguarding risks. They are a requirement of the national safeguarding policy. Inspectors spoke with the designated officer who informed them that this centre had 28 active safeguarding plans in place. When inspectors reviewed the safeguarding plans with the person in charge, she was only aware of 20 plans. This failure to provide proper oversight of the safeguarding arrangements for residents increased the risk of safeguarding issues occurring.

Inspectors reviewed a sample of safeguarding plans for residents living in one of the houses. Inspectors found that each of the residents had a safeguarding plan in place. However, the recommendations from these plans had not been implemented effectively. For example, in some plans it stated that to protect specific residents from safeguarding risks, those resident should have 1-1 staffing at all times. Inspectors found that only two staff were rostered on duty in the house for all seven residents, thereby making it impossible to implement the safeguarding plan. In another, the plan stated that to protect residents from safeguarding risks, there should be separate activities for four of the residents. Again this could not be achieved due to the level of staffing in the house.

Inspectors found that the provider had not taken suitable safeguarding actions in respect of all incidents of unexplained bruising. Records indicated that some residents had experienced unexplained bruising. Inspectors found that not all of these incidents had been managed in line with the centre’s policy as they had not all been referred to the centre's designated officer for investigation. This presented a risk that potential physical abuse might not be suitably identified and resolved.

It was evident from records, including incident forms and complaint records, that residents in one house in the centre were not residing together well. Although there were behaviour management and safeguarding plans in place for the support of these residents, behavioural issues continued to be evident and impacted consistently on the quality of life of residents.

There was a policy on responding to behaviours that challenge to guide staff. Inspectors found that the majority of staff had received behaviour management training. The service of a behaviour support specialist was available to support residents and to guide staff practice. Inspectors viewed a sample of behaviour support plans that had been developed for residents and discussed these plans with staff. Staff were very clear about residents’ support needs and explained proactive and reactive measures that would be used if required. However, residents' behaviour support plans were not being consistently reviewed and updated to include the most current or relevant information. For example, in a one behaviour support plan, a resident's behaviour support needs had changed considerably and the plan had not been updated to show this or to guide staff. This was of particular importance due to the use of agency and temporary staffing throughout this centre on a regular basis.

Environmental restrictive practices were not being used in the centre for behaviour management, although there was limited use of bed rails for safety. There was no evidence that appropriate muldisciplinary guidance, had taken place prior to the introduction of bed rails. An assessment for the use of bed rails had not been carried out. The assessment did not record details of alternatives that had been considered before the decision to use bed rails, although a staff member clearly described the interventions that had been tried and why they had not been suitable.

Inspectors found that the information guiding staff on the interpretation and use of chemical restraint was unclear. Inspectors spoke with staff who told inspectors that 'as required' anti-psychotic medicine used for the management of behaviour that challenges was not a chemical restraint; however, medicines given prior to a medical procedure was.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
Under the regulations, the provider and person in charge are required to submit information to the office of chief inspector in relation to specific notifiable events in their centres. This is an important part of the ongoing monitoring of the safety and quality of the service. Inspectors found that while notifications were being submitted, they were not being submitted within the legally required timeframes. Also, the provider had not submitted a notification with the required information for the person in charge when she was appointed.

In addition, inspectors discussed the submission of notifications with the person in charge and found that she did not have a clear understanding of her responsibilities or legal requirements in relation to notifications.

Of further concern was that the incident records for the centre were not available for the period of March 2016 to April 2017. It is a legal requirement for these records to be maintained in the centre. Inspectors were not able to verify whether the appropriate notifications had been made during this time period.

Judgment:
Non Compliant - Major

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:
Inspectors found that opportunities for development were very different in three of the houses compared with the other three houses. This impacted on the opportunities available to some residents to make choices around training and for the development of daily living skills.

Inspectors found that residents in three of the houses continued to be supported to access developmental and social opportunities in their homes. Residents living in three of the houses had good opportunities for new experiences and to develop further skills while the residents living in the other three houses did not.

For example, residents in three of the houses had been working successfully with staff to develop daily living and housekeeping skills. These residents were involved in basic household chores, such as baking and laundry, as a form of skill building. During the inspection, inspectors observed some residents making meals. The inspector spoke with some residents who stated that they were very pleased to be involved in doing their own laundry, in some aspects of housekeeping, and in shopping and meal preparation. These opportunities also included participation in activities in the local area. For example, some residents who inspectors met were involved in activities that they enjoyed, such as line dancing, a knitting club, and going to the library. One resident told an inspector about playing football and attending football matches, and another spoke of playing golf and displayed a medal for this. A resident with a visual impairment had a membership to a library and could avail of services specific to their needs. A resident with a particular interest in gardening had a set of gardening tools, and looked after the plants and flower boxes at the house.

However, for those residents in the other three houses who did not have the opportunity of actively participating in such skills development, their experience of the living in the centre was less active and engaging and focused primarily on house based activities.

Some residents in this centre were part of the first phase of an upcoming transitional plan, to move from the centre to community based housing, and there were measures in place to support these residents to develop living skills in preparation for the

transition. These residents were involved in increased community activity such as visiting the area of their new homes, and shopping and using amenities there.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Inspectors found that the provider and person in charge had not addressed the actions arising from the previous inspection. Inspectors found that improvements were required to access to general practitioners and in end of life care planning.

Some residents in the centre had poorer access to medical care than other residents. Some residents received care from a campus based service through a general practitioner (GP). However, this cover was only provided for three out of four weeks due to the GP contract agreements. There was no GP cover other than emergency, out of hours services available to residents on the fourth week. Other residents attended the GP of their choice and were supported to access or attend the service as required.

On review of a sample of files for older residents with higher care needs, the inspectors noted a lack of end of life care planning. For example, a personal plan in place did not include end of life guidance or the directives made by residents or their families, where it was noted that there had been a change in the resident's assessed needs. This did not ensure that the spiritual needs, rights and wishes were identified for residents who may require end of life care.

Inspectors found through discussion with staff, that their knowledge of the residents' needs and wishes was not consistent with the resident's personal plans and assessments. In addition, the inspectors noted that the needs of residents who were ageing had not been reviewed or assessed to help determine their changed needs or support requirements.

While residents in three houses had the opportunity to be involved in their own meal preparation and residents in the other houses continued to be reliant on a central kitchen, the food that was prepared for residents appeared nutritious and was consistent with their dietary needs. However, the inspectors noted that records of

dietary intake were only maintained for residents whose care plans were in place from dieticians. Staff had supported residents who required support with eating as guided by speech and language therapists.

The inspectors found that the residents had access to specialised services such as chiropody, mental health services, health screening and occupational health services as required. Registered nurses were completing audits of the care needs of residents and implementing care plans where required such as wound care.

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

Findings:
Inspectors found that the provider and person in charge had not addressed all of the actions arising from the previous inspection. Overall the inspector found on the days of inspection that there continued to be some gaps in the management of medication and further improvements were required in relation to medication administration records, and the storage and disposal of discontinued medication.

Inspectors found that on review of six residents' medication files, the individual self-medication assessments were completed, following a risk assessment. As required medication protocols were in place and were signed by the prescribing practitioner.

Inspectors found that the person in charge had ensured that staff were knowledgeable about medication management practices. However, there continued to be a lack of appropriate medication storage facilities throughout the centre. This meant that discontinued medication could not be stored in a separate area away from medication that was in use.

The inspectors reviewed training records and found that staff had received medication safety training in-line with the provider's policies.

Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors reviewed the statement of purpose and found that although it had been reviewed since the last inspection it did not accurately describe the service being provided in the centre.

The statement of purpose was reviewed and inspectors found that there were gaps evident in relation to the requirements of schedule 1, including:
- admission criteria
- description of the floor plan of all units in the designated centre
- the arrangements made for dealing with reviews of the statement of purpose.

The statement of purpose was not readily available or provided in an accessible format to the residents and their representatives.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that the provider's management systems did not effectively monitor the service to ensure a consistent and good quality of service for all residents in the centre and to ensure that the centre was in compliance with regulatory requirements. In addition, the provider had not monitored the implementation of actions in the provider's own plan since the previous inspection or ensured the effectiveness of those actions.

The provider had not obtained the information required by the regulations to ensure that the person in charge was suitable for the post prior to her appointment. This included an absence of photographic identification, current Garda Vetting, and a contract of employment for the person in charge position.

An annual review of the quality of the service had been completed by the provider, as required by the regulations. However, the provider had identified multiple issues that needed to be addressed in the centre but these remained unresolved at the time of this inspection. In addition, the provider had failed to implement a system of effective oversight and monitoring of the progress, completion or challenges to completing the actions in their annual review. For example, the lack of a psychologist for the service was identified as impacting on residents. No arrangements or guidelines had been put in place for staff or residents on how to access alternative psychology services. In addition, the annual review did not reflect any evidence of consultation with family members or representatives of residents.

Inspectors found that the provider had completed unannounced visits at six monthly intervals, reports of which were available at the centre. However, the actions identified as a result of these visits remained incomplete at the time of inspection. Inspectors found that the timeframe for completion of these actions had lapsed and that these had not been reviewed and updated with a rationale for this lapse. Inspectors were informed that a further unannounced visit had recently been completed; however, the report was not available for review in the centre at the time of inspection. This document was submitted to HIQA after the inspection and inspectors found that this document did not provide a comprehensive review of the service and did not identify the failings identified by the inspectors or the lack of progress in completing actions arising from the providers previous reports.

Prior to commencing this inspection, inspectors had requested an up-date on the actions taken by the provider following the previous inspection. In this update, the provider had told HIQA that 13 of the 21 identified actions had been completed. However, during this inspection, inspectors found that 18 of the 21 actions had not been completed and continued to have a significant impact on the quality and care of the service provided. Furthermore, the lack of progression against these actions had not been identified by the provider in their own audits, annual report or the six monthly unannounced visits completed since the last inspection.

The inspectors found that the management systems in place in the designated centre were not working effectively. Inspectors found that there were no clear guidelines regarding the roles and responsibilities of support staff in the houses where there was no team leader. In addition an up-to-date training needs analysis had not been completed for the designated centre, to ensure that provider had sufficient and suitably

trained staff to meet the needs of the residents.

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 were no actions required from the previous inspection. The person in charge and her line manager were aware of their requirement to notify HIQA of the absence of the person in charge.

The inspectors found that there were arrangements in place to cover the absence of the person in charge both during planned absence and out-of-hours. This arrangement was reflected in the statement of purpose and the inspectors found that the staff were all familiar with the plan in place.

The centre had arrangements in place that ensured there was management presence in the centre and this was recorded in the rosters in the centre.

Judgment:
Compliant

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

Theme:
Use of Resources

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

Findings:
Following the previous inspection, the provider had committed to undertaking a review of staffing levels and skill mix and to ensure appropriate staffing levels were put in place based on this review. However, inspectors found that the provider had not implemented this action.

Furthermore, inspectors found that transport resources provided to the centre did not adequately meet the needs of all residents. These failures impacted on the delivery of care and support to residents and reduced their access to the local community.

Overall on this inspection, inspectors found that the centre was not consistently resourced with a level and skill mix of staff to support residents. Inspectors saw examples where staff were not replaced in the centre when absent. This meant that other staff had to cover their work and were not able to support residents as set out in their personal plans. Inspectors found that residents' personal plans were regularly interrupted due to the unavailability of staff. For example, inspectors were told by the staff and the person in charge that staff regularly attended training during working hours without adequate arrangements to replace them. This meant that planned activities for residents had to be cancelled.

Inspectors found that the provider had grouped residents in a house together that were assessed as having specific staffing support and supervision needs. However, the provider had not ensured that the staffing allocations were adequate to meet these support and supervision needs. As a result, the other residents in that house were not able to exercise personal choice and control of their daily routine or engage in social activities. During a previous inspection of the centre, the provider stated they would undertake a staffing review to ensure that the needs of residents, while in the centre, were being met. The person in charge confirmed that this had not been completed at the time of this inspection. However, a review of staffing needs required for when residents transition into independent living had been completed.

There were a range of transport vehicles available and these were being used to transport residents for trips, shopping outings and community access during the inspection. Residents told inspectors that they enjoyed these outings. However, in some cases due to the limited capacity of the vehicles provided, some residents were not able to participate in activities of their choice. For example, in some houses, the capacity of the vehicles was not adequate for the numbers of residents requiring transport, where one resident who required the vehicle for an appointment, this meant that other planned activities for residents with wheelchairs were cancelled.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the

needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Inspectors found that the provider and person in charge had not addressed the actions arising from the previous inspection. Inspectors found that the numbers and skill mix in the centre did not meet the assessed needs of residents and the provider had not completed a review of the workforce, as they said they would following the previous inspection in October 2016. In addition, inspectors found that there continued to be a lack of appropriate training, recruitment and allocation of resources and skill mix in line with the assessed needs of residents and as required by the regulations.

The inspectors found that a training programme was in place for staff. However, some staff continued to had not received the required mandatory training in the centre. Inspectors reviewed the training records and found that about one third of the staff had not had fire safety training, manual handling training and behaviour support training. The person in charge stated that some training needed to be completed online; however, there was no plan in place for staff to complete this training.

Inspectors found that the lack of sufficient staff was having a negative impact on the quality of life for residents in the centre. On review of the personal plans in place in two houses, it was evident that the centre did not have enough staff on duty to meet residents' needs. For example, inspectors saw where a resident was left unsupervised for extended periods of time when the staff had to assist another resident with care needs. There were specific risks identified for the unsupervised residents and these could not be managed when the staff were assisting a resident with care needs. In another example, in another house, three residents required constant monitoring as specified in their safeguarding plans. Because of this, staff could not attend to the support needs of other residents.

In addition, the inspectors also found that the person in charge had failed to complete a comprehensive review of staff requirements in one house in the designated centre, where there was a decline in a resident's health and wellbeing. Inspectors found that the resident's support needs had increased and the person in charge had failed to review and respond appropriately to this increased support requirement, which was impacting on the other residents in the centre.

Inspectors found that the person in charge, who had recently been appointed, had started to implement the new formal staff supervision arrangements. The person in charge was also engaged in training on supervision as part of these arrangements.

The inspectors reviewed 11 staff files and found that they did not meet the requirements of schedule two of the regulations. For example:
- Garda vetting was not available in all staff files
- unexplained gaps in employment history were noted
- the dates that employment commenced was not recorded
- photo identification was not available on some files
- no relevant contracts were in place for staff in relation to their roles.
- no files were available for cleaning staff and transport staff.

The person in charge had ensured that planned and actual rotas were in place throughout the centre. On review of the rotas, inspectors found that they clearly identified that hours worked by the person in charge and the clinical nurse managers, who were additional to the frontline staff. There were no volunteers in place at the centre, on this inspection.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Inspectors found that the provider was not maintaining some of the records required by the regulations. Inspectors found that there were inconsistencies in the accuracy of documentation and this presented a risk that all aspects of care were not being identified and suitably delivered to residents.

During the course of the inspection, a range of documents, such as the directory of residents, medical records, staff training records, health and safety records and healthcare documentation were viewed. While some records were found to be satisfactory, others did not meet the requirements.

Policies required by Schedule 5 of the regulations were available to guide staff. Overall,

the required policies were available, but while there was a policy on Garda vetting of staff, there was no policy on the recruitment and selection of staff available in the centre. The policy on the use of restrictive procedures required improvement, as it did not provide guidance to staff on the management and assessment of the use of bedrails and lap belts, in line with the requirements of the national policy on restraint.

There was a directory of residents which included most of the information required by the regulations, although the names, addresses and telephone numbers of residents' GPs were not recorded.

Records of the food provided for residents were not being maintained to help determine if a resident's diet was satisfactory, in relation to nutrition and there was not recording of any special diets prepared for individual residents.

In some of the handwritten records viewed by inspectors, the information was not clearly written, and in some cases, was illegible. For example, a restraint audit report was difficult to read, and some accident and incident records were too feint to read.

Although most of the required documents were available for inspectors to view, the accident and incident records for March 2016 to April 2017 were not available. Inspectors asked for these records, but the provider failed to make them available.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Glynn
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004911
Date of Inspection:	16, 17 & 18 May 2017
Date of response:	24 August 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents did not have the opportunity to fully exercise choice around catering and domestic activities.
Some residents did not have the option of preparing their meals, if they wished to.
Some residents did not have the option of using bed linens of their own choices.

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

1. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
1.Residents are supported to make daily food choices with the use of menu plans. These are in pictorial format for residents with communication difficulties. There is also a daily change of mind option available to all residents and second options of meals are offered.

2.Scheduled monthly Voices and Choices Group and house Advocacy meetings reflect residents food and domestic activities choices.

3.Residents are supported to compile shopping lists based on their choices and supported to prepare their meal in each home.

4.Three homes in the centre are moving towards the complete implementation of the social model. See attached appendix 1 for progress to date.

5.All residents in the six homes in the Centre have chosen personalised bed linen and they are in use.

Proposed Timescale: 31/10/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some complaint records did not include outcomes of complaints, and whether or not the complainant was satisfied with the outcome.

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

Please state the actions you have taken or are planning to take:
1.The complaints audit template is revised and completed monthly by the PIC. The results are collated to capture the outcome of the complaint, if it requires escalation and whether or not the complainant is satisfied with the outcome. This is recorded on the complaints report form.

2.The Centre retains a record of all complaints which includes details of the investigation, outcome and actions taken.

3. Residents and/or their representatives are supported by the CNM/Social Care Leader to use the National Advocacy service to ensure that the voice of the resident continues

to be heard within the centre.

4.In addition the complaints procedure will be reviewed in terms of the accessibility of the information contained in it and the ease with which the process for dealing with complaints is understood by residents, in consultation with the residents forum and the Speech and Language Therapist(SALT)

Proposed Timescale: 31/08/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The closing correspondence, sent to residents to outline outcomes of complaints, did not advise residents of the appeals process as required by the regulations.

3. Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
All residents who make a complaint are given an accessible copy by the PIC of the appeals process should he or she wish to appeal the outcome of the complaint. The procedure is explained to the resident by the staff team in each home.

Proposed Timescale: 31/07/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Supports and aids to assist residents with aspects of their communication needs, were not consistently applied through all houses in the centre. In some houses, use of assistive technology was not being implemented for residents as a form of communication development.

Some communication passports did not provide sufficient detail of communication techniques specific to each resident.

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

Please state the actions you have taken or are planning to take:
1.SALTs will provide a communication assessment to identify those who will benefit

from communicative assistive technology and will support the staff team to explore communication solutions.

2.An audit of Communication Passports will take place by SALTS with support and feedback to the staff team in each home.

3.Visual aids/Pictorial activity boards will be developed to support residents with communication difficulties with input from SALT.

4.SALTs will provide training in communication. Training is scheduled for August 30th and 31st in the area of Eating, Drinking and Dysphagia. All staff will also complete the online HSELanD module on communication with people who have an ID.

5.The resident's communication passport will reflect the type of communication system that is recommended to support the resident with communication.

Proposed Timescale: 31/10/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had admitted a resident to the designated centre which was outside of the terms outlined in the statement of purpose.

5. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The provider will adhere to the terms outlined in the statement of purpose. The Authority will be consulted about any situation that may potentially be outside the terms outlined in the Centres Statement of Purpose.

Proposed Timescale: 30/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that written agreements, which detailed the terms on which the residents would reside in the designated centre, had been agreed by the resident or their representative.

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

Please state the actions you have taken or are planning to take:
1.A review of the service agreements was completed on the 17th July.
2.Updated agreements were re-issued to residents and their families on the 17th July 2017. Sixteen families have responded and returned the agreements
3.Keyworkers will follow-up with families to return signed copies by 31st August 2017.A reminder web text will be send to all keyworkers to complete same.

Proposed Timescale: 14/09/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that a comprehensive assessment was completed when residents' needs changed.

7. 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:
The action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that review meetings included the resident or representative, where appropriate.

8. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
1. All residents are offered the opportunity to attend his/her annual review.
2. Families or representatives are formally invited to attend.
3. Residents and their representative will be consistently supported to be involved in Person Centred Planning meetings
4. Minutes of all annual review meetings will reflect that the resident or their representatives were involved in the review meeting.

Proposed Timescale: 30/05/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that the effectiveness of the personal plans was reviewed and that changes in circumstances and new developments were attended to.

9. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
An evaluation of the effectiveness of the current Personal Plans in four homes is due to commence on the 4th September 2017 using a revised evaluation template. This will be completed by the documentation review group as part of their role in the streamlining of the documentation in the six homes in the centre.

A copy of personal plans will be given to each resident.

The SALT team will support key staff to adapt personal plans so that they are available to residents in a suitable format.

Personal plans will be reviewed in line with timeframes or as needs and circumstances change

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that residents' personal plans were available in an accessible format.

10. 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:
1. Resident's personal plans will be available in an accessible format.
2. The SALT Team will support the implementation of same.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that where residents were identified for transition to the community, that information on the services and planned supports required by the resident was available.

11. Action Required:
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

Please state the actions you have taken or are planning to take:
1Transition plans will be reviewed with residents and revised to identify timeframes for transition.
2. The centre will provide information on the service and planned supports required for each resident.

Proposed Timescale: 15/09/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that the premises was maintained and repaired internally and externally in a timely manner throughout the designated centre.

12. 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:
1.A maintenance audit of Centre 3 has been completed

2.A planned maintenance programme for the period up to the 31st December 2017 has been instigated.

3.The programme includes upgrades under a number of headings to include: painting, footpaths / egress, external lighting upgrades, floor / surface upgrades, external cleaning programme, suspended ceiling upgrade, bathroom upgrades, kitchen upgrades.

4.The works have been costed, approved and have commenced, this is to be monitored on a weekly basis at the Management Team meeting to ensure timelines are being maintained .

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure the designated centre met the requirements of schedule 6.

13. 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:
1.A maintenance audit of Centre 3 has been completed

2. A planned maintenance programme for the period up to the 31st December 2017 has been instigated.

3. The programme includes upgrades under a number of headings to include: painting, footpaths / egress, external lighting upgrades, floor / surface upgrades, external cleaning programme, suspended ceiling upgrade, bathroom upgrades, kitchen upgrades. The renovations to the bathroom area in one home are complete.

4. Monthly audit and monitoring of internal and external premises by the Person in Charge.

5. Check list for daily monitoring of external emergency lighting and pathway egress to be developed and placed with daily logs.

6. Develop a daily routine check list for each home to ensure that equipment is cleaned and maintained.

7.Annual services of all equipment and a copy of reports are to be maintained in the centre CNM office

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that all areas internally and externally were clean and suitably decorated throughout the designated centre.

14. 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:
1.The PIC and CNMS will put in place a cleaning schedule in each home as part of the daily routine.

2. A daily routine check list will also be developed for each home to ensure that equipment is cleaned and maintained.

3. A planned maintenance programme for the period up to the 31st December 2017 has been instigated. A central log of all agreed works will be monitored to ensure timelines for completion are maintained. If not they will be escalated and discussed at monthly senior planning meetings.

4. The programme includes upgrades under a number of headings to include: painting, footpaths / egress, external lighting upgrades, floor / surface upgrades, and an external cleaning programme.

Proposed Timescale: 31/12/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that appropriate infection control measures were in place and that all staff had completed appropriate training in line with national policy.

15. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
1.Infection Control policy in place with hand hygiene training schedules rolled out for all staff.

2. One staff member has been identified and trained as Hand Hygiene Instructor to support this.

3. Hand Hygiene training commenced the week 10th July 2017 and is planned for the coming months.

4. All cleaning staff will adhere to Infection Control guidelines in relation to cleaning. Infection control / environmental audits to take place to ensure compliance. Infection control/environmental audits will take place to ensure compliance by the centres manager and the cleaning supervisor on a quarterly basis. The results are relayed back to staff by the manager at unit meetings

Proposed Timescale: 31/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider did not have a copy of the most recent fire risk report completed, available for review in the designated centre and could not demonstrate how they were using the recommendations to ensure effective fire safety arrangements were in place in the centre.

16. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
1.Fire safety assessment report is complete and is available for viewing in the centre. Risk assessments have been altered to reflect it.

2.The HSE has committed finance to a programme of fire compliance structural works which is currently underway. Timelines are finalised. See Gantt chart.

3.Fire safety training is facilitated by an external Fire company and is mandatory for all staff. Training is audited on a monthly basis and staff are informed via web text of the date fire the next fire training.

4.The planned maintenance programme includes footpaths/egress and external lighting to ensure safer and more efficient egress from the homes in the centre.

5.There are adequate numbers of staff available to evacuate residents during the day and at night.

6.A minimum of four fire evacuation drills are completed in the centre per year on day and night duty. A log detailing same is recorded and available

7.A personal emergency evacuation plan is available for each resident in each home. This is regularly reviewed and updated to reflect the changing needs of each individual by staff.

8.The health and safety folder in each home includes a fire register and daily fire safety checks are in place to maintain safety in relation to fire. Monitoring of checks are signed by staff to maintain responsibility at all levels.

Proposed Timescale: 31/01/2018

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Emergency lighting in the centre was inadequate.

17. 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:
1.A risk assessment of all emergency lighting is complete by an external Fire Consultancy Company. This has informed the Centres own risk assessment on this issue.

2. The HSE has committed finance to a programme of fire compliance structural works which is currently underway. Timelines are finalised (See attached Gantt Chart).

Proposed Timescale: 31/01/2018

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that fire doors were in place in the designated centre, as recommended by their own fire safety expert.

18. 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:
1. The HSE has committed finance to a programme of fire compliance structural works which is currently underway. Timelines are finalised. See Gantt chart.

2. Adequate number of staff are maintained to assist in evacuation of residents both during the day and at night in the event of a fire.
3. A pager system is in place and equipment will continue to be checked on a daily basis
4. A pager check log is maintained in the fire register folder as part of the safety checks.
5. The Night Supervisor post has been filled and will remain in place to oversee the safety and welfare of residents during the night time hours.
6. Regular fire evacuation drills will continue to be completed in the centre and record of same maintained in the fire register folder.
7. A personal emergency evacuation plan (PEEPS) is available for each resident in each home, and the PEEP will continue to be reviewed and updated as needs change.

Proposed Timescale: 31/01/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An assessment for the use of bed rails was not in sufficient detail and was not in line with the requirements of the national policy on restraint.

Guidance for staff on the interpretation and use of chemical restraint was unclear

19. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not been provided with adequate, up to date information to ensure that they were knowledgeable about the behaviour support needs of residents. Some information to guide staff in behaviour support was not up to date. Behaviour support plans were not being reviewed and updated regularly and did not include the most up-to-date information available to guide staff.

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

Please state the actions you have taken or are planning to take:
1A new referral system has been introduced since 22nd May 2017 called the FIS referral (Finding and implementing solutions).

2.Audit of practice in the implementation of behaviour support plans will be completed by the Clinical Nurse Specialist and a report completed by 30th September 2017.This will be followed by a detailed SMART action plan

3. A review of all Behaviour Support Plans is scheduled for completion on October 31st 2017. All plans will thereafter be reviewed quarterly or more frequently if required.

Proposed Timescale: 31/10/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not received behaviour management training.

21. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
1.Studio 3 Programme is the behaviour management and 1 day refresher training programme in the centre and is mandatory.

2.Three staff in the service are now train the trainers in this area

3.Staff are rostered to the three day training and one day refresher training every two years. There is a training calendar in place.

4. The PIC audits mandatory training on a monthly basis and reminders are sent to staff via the webtext system when training is due
.
5.A Training Needs Analysis will be completed to reflect the training priorities in each home.

6.All mandatory training records are reviewed on a monthly basis through the local QPS Committee, to ensure that targets are being met to ensure that all staff in the service are trained.

Proposed Timescale: 31/12/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not ensured that all external workers contracted to the centre had been suitably trained in safeguarding.

22. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
1.Two staff onsite have completed the Train the Trainer programme on the National Safeguarding Policy and facilitate training to all grades of staff including external contractors providing services to the centre.

2.Safeguarding training schedule is in place and is mandatory.

3.The PIC completes a monthly audit on safeguarding training and presents the findings to the steering group forum.

4.The Designated officer works in liaison with the PIC and staff teams in each home and conducts regular unannounced inspections to ensure that all safeguarding plans are implemented and staff are knowledgeable on safeguarding.

Proposed Timescale: 31/05/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge was not ensuring that appropriate investigations of safeguarding concerns such as unexplained bruising were being undertaken.

23. 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:
1.The Designated Officer with responsibility for safeguarding will continue to work in close liaison with the PIC to implement the safeguarding policy.

2.The Designated Officer is receiving support and supervision form an experienced social worker with a background in disability.

3.All safeguarding concerns are raised with the regional Safeguarding Team for advice and input.

4.Following a report of any unexplained bruising the PIC and the D.O. act immediately to safeguard the resident and investigate the cause of the harm/injury which has occurred.

5.The investigation is in line with best practice and involves working closely with staff working in the home and the resident who has sustained the injury.

6.The PIC and the D.O. adhere to the safeguarding policy at all stages of the investigation.

7.Where there is a safeguarding plan in place and the safeguarding concern persists the PIC and the D.O. explore all other avenues to establish a possible cause such as recording of incidents of behaviours of concern, twice daily body scans ,unannounced inspections in the home, observations of care and a review of all medication that the resident is currently prescribed.

8.All findings are reported to the Regional Oversight Safeguarding team.

9.Promoting a culture of learning and developing a safeguarding culture is a priority for the centre. There are Incident Review Meetings during the working week (Monday Wednesday and Friday morning). These meeting are attended by both the designated officer and the CNS in behaviours that challenge. This meeting is designed to triage incidents and to identify what is identified as an abusive or a behavioural concern.

10.Following the Incident Review Meeting, the Designated Officer, PIC and/or the CNS in Aras Attracta will act immediately to investigate or review the cause of harm/ injury/ self injury, which has occurred without delay. This investigation is in line with best practice and involves working closely with staff operating in the accommodation and the individual requiring the support.

Proposed Timescale: 31/05/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was poor oversight and governance of safeguarding plans. Sufficient measures had not been implemented to ensure that residents were protected from the risk of abuse.

24. 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:
1.Staff managers and the designated officer are now clear on the number of active plans that are in place. This is now a standing item on every handover

2.In addition the themes of the safeguarding concerns from the centre are reviewed on a monthly basis to identify patterns of when and how they occur.

3.All safeguarding plans are inspected, discussed and/or reviewed for either closure or extension at regular intervals by the Designated Officer and the staff team.

4.Modifications to the plans are added in line with changes in the safeguarding process within the home.
5.An updated version of the plan is developed.

6.The Designated officer works in liaison with the PIC and staff teams in each home and conducts regular unannounced inspections to ensure that all safeguarding plans are implemented.

7.There are monthly scheduled oversight committee meetings where all safeguarding issues are presented and reviewed with the Regional Safeguarding Protection team.

Proposed Timescale: 02/08/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person In charge had failed to ensure that incidents were reported to the Chief Inspector, within three days, as required in the regulations.

25. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
1.All notifiable events will be completed and notified to the authority in line with the regulations and within the designated timeframes.

2.A log is maintained in the centre of all notifications submitted.

Proposed Timescale: 31/05/2017

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:
Some residents in the centre had limited opportunities and choices around training and for the development of daily living tasks.

26. 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:
1.Through discovery and exploration each resident will be supported to identify their own interests and assets. This will contribute to areas of opportunity for each resident to achieve highly valued social roles and can therefore identify choices for education, training and employment.

2. An assessment will be completed by each key worker and supported by the occupational therapist. This will be completed with each individual that will identify education training development employment goals/objectives with each person. Based on the findings goals in this domain will be identified in the person's individual personal plan.

3. The documentation review working group are currently distributing and implementing Independent Living assessments. These focus on daily living tasks and support the resident by setting goals for independent skills. They are reviewed quarterly.

Proposed Timescale: 30/11/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not provided end of life guidance for residents and families where required.

27. 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:
The action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that residents had suitable access to a general practitioner on one week in every four.

28. Action Required:
Under Regulation 06 (2) (a) you are required to: Ensure that a medical practitioner of the resident's choice or acceptable to the resident is made available.

Please state the actions you have taken or are planning to take:
1.A GP rota is now in place for all out of hours and weekend requirements.

2.Residents in three homes in the centre have transferred their medical card to the GMS system and have their own General Practitioner. Residents in the remaining three homes are currently in the process of transferring to the GMS system so they can then access a general practitioner of their choice in the community. As the service transitions to the social model of care and to the community residents will be offered GPs of their choice in the area they are moving to.

3.A GP rota is now in place for all out of hours and weekend requirements

Proposed Timescale: 30/09/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not ensured that a centralised practice in place for the catering for some parts of the designated centre were discontinued.

29. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
1.The remaining three homes are moving towards a social model of care. Catering services are reducing in line with this process.

2.As transition to the community commences and numbers reduce, by October 2017 all of these homes will be fully independent in buying, preparing and cooking their own meals.

Proposed Timescale: 31/10/2017

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:
Discontinued medications were not being stored in an area away from medication that was in use.

30. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
1.Medication Management policy has been amended to reflect that all medications that require return to pharmacy must be arranged to be sent to the outer pharmacy immediately or to community pharmacy where biodose system of medication administration is dispensed.

2.Medications that require return to pharmacy are stored in a separate secure "return to pharmacy" container.

Proposed Timescale: 31/05/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that a copy of the statement of purpose was available in an accessible format for the residents and their representatives throughout the designated centre.

31. Action Required:
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

Please state the actions you have taken or are planning to take:
1. The SOP will be provided in a more accessible format with support from the speech and language therapy service.

Proposed Timescale: 31/08/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that the statement of purpose contained the information required as set out in schedule 1:

- admission criteria
- description of the floor plan of all units in the designated centre
- the arrangements made for dealing with reviews of the statement of purpose.

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

Please state the actions you have taken or are planning to take:
1. The statement of purpose for the centre will reflect the admission criteria, description of floor plans and arrangements for dealing with reviews of the SOP.

2. The PIC will forward an amended version of the SOP to the authority.

Proposed Timescale: 14/09/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure the person in charge met the requirements of schedule 2 of the regulations

33. Action Required:
Under Regulation 14 (5) you are required to: Obtain the information and documents specified in Schedule 2 in respect of the person in charge.

Please state the actions you have taken or are planning to take:
1 .A full review of all staff files is currently underway to ensure that they meet the requirements specified in Schedule 2.
2 .Weekly audits will then be conducted on a random group of files by the Administrator.
3.The PIC will complete quarterly audits to ensure Schedule 2 information and

documents are in place for all staff including full time, part time, agency and ancillary staff who work in the centre.

Proposed Timescale: 30/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that arrangements were in place to consult with residents' family and their representative when conducting the annual review of the quality and safety of care and support in the designated centre.

34. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
1.There is an annual review of quality and safety of care in the designated centre.

2. Through the family forum meetings with and service satisfaction survey/questionnaire, insights are gained from families about the quality and safety of care and support. These will be profiled and included in the annual review by the PIC.

3. A copy of the annual review will be made available to residents in an accessible format and displayed in a prominent place for residents to access.

Proposed Timescale: 31/10/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that the plan put in place to address the concerns identified in the six monthly unannounced visit had been completed within the described timescales.

35. 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 action plan submitted by the provider does not satisfactorily address the failings

identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to put management systems in place which ensured that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored

36. 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 action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue

Proposed Timescale:

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Suitable arrangements were not in place to provide cover for staff who were attending training during working hours or to cover vacancies in critical roles when staff were on long term leave.

In some cases the allocation of the transport vehicles was not appropriate to the numbers of residents in the houses, which could result in planned activities being cancelled.

The provider had not completed a review of staff required to meet the needs of residents as described in their previous action plan response.

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

Please state the actions you have taken or are planning to take:
1. A staffing review has been completed and skill mix has been identified in order to effectively manage the Centre. This process requires the relocation of some grades of staff who will be transferred into the Centre.
2. The HR department have been working intensively with the management of the centre to address and reduce all attendance management issues. To ensure that the required numbers of staff are available to meet the assessed needs of the individuals requiring support on a daily basis.
3.An allocation of agency staff are available and utilised to cover planned and unplanned activities. There are active permanent staff recruitment panels. The centre is going through the transition process with regular reviews of staffing levels and skill mix due to the de congregation plan for the Centre and the change to social care model of care.

Proposed Timescale: 31/10/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that the staff files met the requirements of schedule two, including full time, part time, agency staff and auxiliary staff who worked in the designated centre.

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

Please state the actions you have taken or are planning to take:
1.A full review of staff files is currently underway to ensure that they meet the requirements specified in schedule 2.

2.Weekly audits will then take place on a random group of files by the Administrator.

3.The PIC will complete quarterly audits to ensure Schedule 2 information and documents are in place for all staff including fulltime, part time, agency and ancillary staff who work in the centre.

Proposed Timescale: 30/09/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that the skill mix and number of staff in the centre

could meet the assessed needs of residents.

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

Please state the actions you have taken or are planning to take:
1.A staffing review has been completed and skill mix has been identified in order to effectively manage the Centre. This process requires the relocation of some grades of staff that will be transferred into the Centre.

2. The HR department have been working intensively with the management of the centre to address and reduce all attendance management issues. To ensure that the required numbers of staff are available to meet the assessed needs of the individuals requiring support on a daily basis.

3. An allocation of agency staff are available and utilised to cover planned and unplanned activities. There are active permanent staff recruitment panels. The centre is going through the transition process with regular reviews of staffing levels and skill mix due to the decongregation plan for the Centre and the change to social care model of care.

Proposed Timescale: 30/09/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that all staff had completed a cycle of mandatory training which included refresher training, in line with the local requirements. There was no training needs analysis completed to identify any further training requirements to meet the assessed needs for residents in the designated centre.

40. 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:
1.A planned training schedule is in place for all mandatory training.

2.The PIC completes a monthly audit on training and presents the findings to the monthly Steering forum. Actions are instigated if mandatory training obligations are unmet.

3.A training needs analysis reflecting the needs of the residents is currently being

conducted. The results will be analysed and inform the training plan for the year. This plan will reflect the health and social skills of each resident in addition to meeting the mandatory training obligations.

Proposed Timescale: 30/09/2017

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 policy on the recruitment and selection of staff was not available in the centre.

The policy on the use of restrictive procedures did not provide guidance to staff on the management and assessment of the use of bedrails and lap belts, in line with the requirement of the national policy on restraint.

41. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
1. The policy on the recruitment and selection of staff will be available in the PPG folder in each home.
2. The policy on the use of restrictive practices is under review.
3. Bed rails are used for one resident in the centre.
4. Bed rails are only used when a risk assessment has determined it is the most appropriate solution to prevent falls.
5. The initial assessment is completed in line with the National Policy on Restraint and the HIQA Guidance document on the use of Restrictive practices. The results of the assessment establish that bedrails are the most appropriate course of action and are a last resort.
6. Measures are in place to control risks to the resident's safety for the use of bedrails. These measures adhere to regulations and National policy and are reflected in practice.
7. Regular audits are conducted on the use of restrictive practices in the centre and are available for viewing.
8. Restrictive practices are only introduced through a collaborative approach by the members of the Multidisciplinary Team.

Proposed Timescale: 30/09/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
The directory of residents did not include the names, addresses and telephone numbers of residents' GPs.

42. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
The Directory of residents is updated and includes the names, addresses and telephone numbers of residents GPs.

Proposed Timescale: 31/05/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of the food provided for residents were not being maintained to help determine whether a resident's diet was satisfactory and there was no recording of special diets prepared for individual residents.

43. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
1.A daily flow chart highlights the volume of fluid and nutritional input per resident. Detailed food and fluid diaries are maintained for any resident who has been assessed and is at risk in this centre.

2.Menu options are available to residents in an pictorial format. Meal ordering forms are completed with residents each day; these include specific dietary requirements and are available for inspection in the centre.

3.A menu is available and on display and in an accessible format for each resident.

4.The meal ordering forms are completed each day and include specific dietary requirements. Order forms are kept and available for inspection in the Centre. The daily flow chart of care is completed.

5.Where there are modified diets recommended, they are recorded in the daily flow chart of care. This flow chart also highlights the volume of fluid and nutritional input.

Proposed Timescale: 31/05/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Accident and incident records between March 2016 and April 2017 were not provided to inspectors to review.

Some accident and incident records were too faint to read and were not legible.

44. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
1.All incidents and accident reports are recorded on an Incident Report Book.

2.There are three copies of same. The original copy is uploaded onto National Incident Management System each week. The yellow copy is returned to the residents file to implement actions as required. The blue copy remains in original Incident Report Book.

3.It is recommended for viewing purposes that the original white copy is read from a legibility perspective or viewed off the National Incident Management System.

Proposed Timescale: 31/05/2017