

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Upper Woodlands Close
<b>Centre ID:</b>	OSV-0005313
<b>Centre county:</b>	Sligo
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Teresa Dykes
<b>Lead inspector:</b>	Thelma O'Neill
<b>Support inspector(s):</b>	Stevan Orme
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	30
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
03 October 2016 09:30	03 October 2016 20:00
04 October 2016 09:30	04 October 2016 19:30

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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

Background to inspection:

This was the fourth inspection of this centre by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to inform a registration decision, to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. The actions from the previous inspection were also reviewed on this inspection.

At the last inspection, 37 failings were identified. The provider was requested to submit an action plan outlining how they would address the outstanding issues and bring the centre into compliance. This inspection focused on the providers' response

to the previous action plan, and it was found that a substantial number of actions had not been addressed.

How we gathered our evidence:

Inspectors met with residents, staff members and the management team during the inspection process. Inspectors observed practices and reviewed documentation, including personal plans, accident and incident reports, policies and procedures, fire management related documents and staff files.

Description of the service:

This service is managed by the Health Service Executive (HSE). It is located outside the town of Sligo. This service was part of a congregated setting accommodating 100 residents. The provider had recently reconfigured the service into four designated centres each with their own management structure. This designated centre provided residential accommodation and day services in seven houses to 30 residents with moderate to severe intellectual disability.

Overall Judgment of findings:

The inspectors observed staff attending to residents in a kind and caring manner. Staff that the inspector spoke with were very familiar with the residents individualised needs and wishes. Most of the residents had lived in this centre all their life and residents that could speak told inspectors they were generally happy living in the centre. Some residents and staff said they were looking forward to moving to the community next year.

The findings of this inspection identified eight major non-compliances with the regulations which impacted on the safety and welfare of the residents in this centre. These included Social Care Needs, Safe and Suitable Premises, Health and Safety and Risk Management, Safeguarding and Safety, Medication Management, Governance and Management, Workforce and Records and Documentation.

A number of fire-related concerns were identified during inspection. Upon inspection, inspectors issued an immediate action in relation to fire management arrangements. These included the obstruction of fire escape routes and the inaccessibility of fire door keys by staff in the event of a fire in the centre. In addition, poor fire prevention practices were observed to include the wedging open of fire doors. The centre's evacuation plan was found to be unclear and staff were unfamiliar with the plan. Residents' personal emergency evacuation plans reviewed by inspectors were not reflective of the assessed needs of residents.

The management systems in operation by the centre remained a concern and were identified on previous inspections. Inspectors continued to find limited management oversight to ensure effective systems were in place. This oversight was required to ensure services provided were appropriate to residents needs, consistent and effectively monitored. For example, the inspector found that the responsibility for the delivery of services for one house had been commissioned to an external provider. However, the governance and management arrangements for this house were not clear and did not meet regulatory requirements.

Inspectors noted a lack of governance and management systems in place to detect areas of non compliance in the centre. For example, there was a lack of consistency in the allocation of staffing resources to meet the needs of residents. This directly impacted residents' quality of life. For example, where residents required one to one staff support to carry out their activities of daily living, they were not receiving the staffing support required.

An out of hour's service of senior management cover was in operation at the centre. However, this service was not clearly defined. The scope of this service was not supported by operational procedures or job description to guide staff on their responsibility and role as senior cover manager for the centre.

The absence of appropriate transitional plans was noted by inspectors where residents had moved between houses within the centre. Failings were observed in the pre-admission process where residents were moved to live in different houses, but the suitability of these individuals to live together was not appropriately assessed. As a result, this had a negative impact on the residents' concerned. For example, the safeguarding and social care needs of residents.

The design and layout of bungalows continued to be inadequate and did not meet the needs of residents. This was unchanged from the previous inspection visit.

Inadequate systems were in place to ensure the timely maintenance of the centre's heating system. Inspectors observed poor management of maintenance-related incidences. For example, management were alerted to failings in the centre's heating system, but there was insufficient evidence to suggest that adequate measures had been taken to mitigate the risks identified. This resulted in negative outcomes for the residents' residing in the centre.

The cleanliness of the centre was not found to at a high standard. During inspection, inspectors were informed that the cleaning services at the centre had been suspended a few months previous.

These findings are discussed further in the report and included in the reports' Action Plan. Where previous actions were not addressed, these have been reinstated 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:**

The inspectors found the centre did not adequately promote residents' rights, dignity, choice and privacy. There were four actions issued following the last inspection. These actions were reviewed and had not been addressed.

Following the previous inspection, there were no significant changes in the premise to improve the residents' privacy. For example, inspectors found the continued use of shared bedrooms and a lack of storage facilities for residents' personal items. Furthermore in some chalets, bedroom doors had peep holes, which allowed staff to observe residents in their bedrooms. This impacted the residents' right to privacy and dignity.

Although complaints were adequately responded to and the complainants' satisfaction recorded, the complaint's policy was not displayed in some houses. Furthermore, advocacy services were not available to residents living in the centre.

There were no restrictions to visitors to the centre. However, the chalets did not provide adequate private space to accommodate visitors.

A sample of residents' personal financial records were reviewed by inspectors and were maintained in line with the provider's policy, although there were no financial competency assessments completed in line with the findings from the inspection in November 2015.

**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:**

The inspectors found residents' communication needs were not adequately assessed by a competent person.

There was a communication policy in place in this centre. Staff were knowledgeable regarding residents' communication needs. However, inspectors found no evidence of communication assessments, including the potential benefit for residents' of using assistive technology to communicate. This was an action from the last inspection which had not been completed.

**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):**

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

**Findings:**

Residents were supported to maintain links and to have positive relationships with their families and friends. Many residents living in this centre had a good relationship with family and friends. Some residents who had lived in the centre for many years but, had limited contact with their family. Other residents went home regularly for a night or

weekend, or visited for Easter or festive occasions throughout the year.

Staff told the inspectors, that some families attended resident's personal plan meetings and reviews and there was documented evidence of their attendance and involvement in residents' visiting records.

The organisation had a visitor's policy to guide the best practice. Staff told inspectors that there were no restrictions to residents having visitors in the centre. However, on the previous inspection inspectors found that some houses did not have a sitting or visiting room for residents to meet with their visitors in private. This action was reviewed on this inspection, and inspectors observed that residents still did not have access to suitable facilities to meet visitors.

Residents were developing their shopping skills with staff support as part of the transitioning to community plan. Some residents told inspectors they enjoyed accessing the community facilities more frequently.

**Judgment:**

Substantially 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:**

Residents contracts of care were not in line with the Regulatory requirements.

Inspectors reviewed a sample of residents' contracts of care and found that they did not consistently include information on fees to be charged or additional fees that could be incurred. Furthermore, contracts in some cases were not signed by the resident, their representative or the provider. This was an action from the last inspection that was not addressed.

**Judgment:**

Non Compliant - Moderate



**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

All residents had a personal plan which indicated their likes, dislikes and preferences and supports required in areas such as health and social care, community activities and dietary needs. Residents had annual social goals. However, inspectors found these were recreational and not developmental. For example, a number of residents were due to transition to live within the community before the end of the year, and their personal plans did not identify any development goals to support this transition.

Furthermore, while goals were identified, they did not specify who would support residents to achieve their goals or the timelines when goals were to be achieved. In addition, the progress towards achieving goals were not reflected in daily care notes reviewed by the inspectors.

Residents' personal plans did not consistently incorporate a multi-disciplinary approach to facilitate an evaluation of the effectiveness of interventions provided. For example, inspectors found that residents' ability to achieve their desired goals was impacted by vehicle and staff shortages, but this was not reflected in the resident's personal plan records and there was no evidence of what action was taken to rectify these issues. Consequently they were often impacting daily on the residents' quality of life.

Care plans were not reviewed consistently for all residents. Furthermore, review meeting records did not reflect either the residents or their family's attendance at meetings. This was an action from the last inspection that was not addressed.

Where residents had moved between houses in the centre, inspectors did not find appropriate transitional plans or a review of the arrangements in place. In addition, where incompatibility of residents living together was identified, no action was taken to rectify this situation. Furthermore, where residents were identified to move to the community, transitional plans were not in place for all residents.

There was an admission to this centre in 2016. However, they did not receive a pre-admission assessment as required by the regulations and personal-care notes were not maintained.

Residents had access to their General Practitioner. However, they had not had annual health reviews completed and some residents had not had a reviewed since 2011. This was an action from the last inspection that was not complete.

**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:**

Thirty residents lived in seven bungalows in this designated centre. On previous inspections, inspectors found that the design and layout of the bungalows were inadequate and did not meet the needs of the residents. This had not changed.

Of the seven bungalows, two bungalows accommodated seven residents each, two bungalows accommodated five residents, one house accommodated four residents, and two houses accommodated one resident each. Four residents shared two bedrooms, this impacted on residents' privacy and dignity. In addition, there was inadequate communal space for residents to meet visitors in private.

Inspectors reviewed the requirements of schedule 6 in the Care and Support Regulations 2013. These requirements were not met, which significantly impacted on residents' quality of life. For example, in December 2015 the heating system had failed resulting in over 55 residents being relocated to emergency accommodation for a period of time. Although assurances were received from the provider that the heating system was working adequately, inspectors saw evidence the heating system had broken down on several occasions over the past few months and was still not working adequately on the day of inspection.

Staff told inspectors that in some houses, there was no thermostatic control for the heating resulting in an inability to control the temperature in the houses.

There was inadequate equipment to meet residents' needs. This included fire safety equipment, assistive technology, mobility and bathing equipment. Furthermore, communal space, toileting and catering facilities were inadequate in the centre.

Some houses in the centre were not clean; window cills had dirt and dust on them. Inspectors saw a linen room where significant mildew was present and there was contact with residents linen and bed wear, which was an infection-control risk. In addition, inspectors observed in the linen room a significant amount of lint at the back of the tumble dryer and on the ground which created a high fire risk, but there was no cleaning schedule in place for its removal. Inspectors were told that cleaning services had been suspended in this house a number of months previously, and this was impacting on the cleaning activities in the house.

**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:**

Significant risks in Health and Safety and Risk Management were identified in this centre, which was not in compliance with the Care and Support Regulations 2013.

The managers identified risks in the centre on a risk register. However, this was not a working document as it was not updated since August 2016 and did not identify risks observed by the inspectors. For example, the location and storage of oxygen cylinders, damage to property, and fire safety procedures. Furthermore, risks identified on the centres' register were risk rated high for over a year, but were not addressed.

On this inspection, inspectors issued an immediate action in relation to fire management arrangements at the centre. Inspectors found fire doors were wedged open, and did not close properly. Furthermore, fire exits were obstructed and could not be opened in the event of a fire. In addition, where fire doors required a key to open, a key was not consistently available to all staff. Additionally, in one house the fire escape route to the rear of the building was locked and could not be opened, thereby potentially causing resident and staff to be trapped at the rear of the building in the event of a fire.

The fire evacuation was unclear and staff were not familiar with the evacuation plan, procedures or equipment in the centre. Emergency lighting had not been replaced as recommended by the organisations fire equipment consultant and there was a lack of emergency lighting at the rear of one of the houses. Furthermore, all staff did not have up-to-date fire safety training.

Resident's evacuation plans (PEEPs) were not reflective of their assessed needs. For example, aids and equipment required to evacuate residents were not identified. In addition, staff support required for evacuating the residents' were also not specified on their PEEPS.

Fire evacuation drills were not conducted across the centre using minimum staffing levels. This resulted in inadequate assessments of fire evacuation requirements in some of the houses inspected. For example, in some houses there was only one staff member on duty at night to evacuate up to seven residents.

There was a quality risk review group in place in the campus. This group met regularly to review and manage risks reported in all centres in the campus and community services. However, inspectors found incidents of aggression were frequent, but the control measures were ineffective. For example, incidents of peer on peer physical abuse, or psychological abuse were regularly reported but not appropriately managed.

Safe moving and handling practices were not adequately risk assessed in the centre. Some premises did not have adequate showers or bathing facilities, resulting in the staff lifting bathing equipment in and out of the bath when required. Although moving and handling issues were identified by staff in the centre, these risks were not managed adequately, and staff did not have up-to-date training in safe moving and handling practice.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

Inspectors reviewed the four actions from the last inspection. None of these actions were completely implemented.

Inspectors found that in general residents' safety was maintained at the centre. Some

residents had safeguarding plans in place to manage behaviours of concern or incompatibility of residents living together.

In most houses, these issues were found to be well managed and safeguarding plans were implemented, therefore, ensuring residents were kept safe. However, inspectors found that residents moving between houses had resulted in safeguarding issues for other residents.

Inspectors found the compatibility assessments of residents living together or proposing to live together had not been completed or risk assessed. As a result, the inspectors saw that following transitions of residents to new houses, preliminary safeguarding screening took place. However, inspectors found that safeguarding concerns identified incompatibility of residents, as a safeguarding issue in the houses since the transfers. However, the outcomes of the screening and the actions required to manage the safeguarding issue had not been reported back to the individual residents or staff members. This resulted in residents safeguarding plans not being appropriately implemented. Furthermore, all staff working at the centre did not receive training on safeguarding vulnerable residents.

Inspectors reviewed the management of behaviours that challenge and found that all residents who required behaviour management assessments had them in place. However, recommendations outlined in the plans were not always implemented due to staffing shortages, or unfamiliar staff working at the centre. In addition peer on peer abuse was a concern in some houses in the centre, although recognised by managers and staff as a concern, the impact of such behaviour on residents' quality of life was not adequately assessed or managed.

Accidents and incidents that had occurred at the centre as a result of behaviours that challenge. These issues were reported to management. However, in some files viewed evidence showed that recommendations following accidents incidents were not always reviewed and updated, and the appropriate support measures were not always put in place to prevent recurrence of these incidents. Furthermore, staff working at the centre did not have training in managing behaviours of concern and this impacted on behaviour support plans being appropriately implemented.

Inspectors reviewed restrictive practices in operation at the centre and found that in some cases they were not adequately risk assessed and managed. For example, in one house all resident's personal care items were locked away to manage the behaviour from one individual. This was negatively impacting on all the residents.

**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):**

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

**Findings:**

Residents did not have opportunities to experience social participation, education and training on a frequent and consistent manner.

Inspectors reviewed residents' daily activity programmes and found that some residents attended full-time day services, and other residents' received a part-time service. Residents living in the centre were dependent upon the staff working to accompany them to social activities, such as, horse-riding or shopping. However, these activities were not always attended, due to staff shortages and transport issues.

A room was available in the main campus building to offer residents opportunities to socialise with other residents and to participate in table top activities, such as jigsaws, painting, and drawing. However, inspectors observed that staffing shortages and transport issues were impacting on residents' access to daily activities. These were actions from the previous inspection that had not been addressed.

There were beneficial facilities such as a hydrotherapy swimming pool and a large gymnasium available in this centre. Although some residents had identified their wish to use these facilities in their personal plans, staff advised inspectors that access to the swimming pool was limited, due to the restricted opening times and pre booking of the swimming pool by external groups.

Some residents were identified to transition to the community before the end of 2016. However, on review, there were no supports plans in place to promote continuity of education, training and employment for these residents following transition. Furthermore, transitions between houses were not managed along the way that ensured residents continuity of care and daily activities, and staffing were maintained. This had a negative impact on the resident's well being. For example, safeguarding issues and general welfare and development issues occurred due to inappropriate placements and inconsistent staffing been maintained at the centre.

**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:**

There were four actions identified on the last inspection. One action was addressed, and three were not complete. These actions related to the provision of food at the centre from the centralised canteen.

Residents' acute healthcare needs were well met. Residents were individually assessed and monitored by the General Practitioner (GP). A GP visited the centre twice a week to attend to residents healthcare needs. At the last inspection, inspectors were told that annual medical reviews for residents were on-going, but on this occasion, inspectors found that some residents had not received annual medical checks and some residents had not had preventative checks since 2011.

Inspectors reviewed residents' health care plans and found them to reflect resident's individual needs and offered clear guidance to staff on how to attend to the residents' healthcare needs. Progress notes were completed for each resident which documented the care provided. Residents had access to allied healthcare professionals such as general practitioner, speech and language therapist, dietician, and a Physiotherapist.

Residents' choice to engage and participate in meal preparation was limited. Residents' access to cooking facilities was not fully available at the centre. The inspectors found the current practices, and facilities promoted the institutional practice that impacted on some residents' rights. For example, a centralised kitchen continued to provide all the meals for the residents in this service and meals were supplied via a hot box to each house at set times daily; 12.30hrs. and 16:30hrs. This was found to limit choice and variety available to residents regarding their meals and schedules.

In addition, the main kitchen closed at 15.00hrs. at the weekends and staff provided meals to residents on those occasions, however, residents' and staff had not received up-to-date training on safe food management and infection control policies and procedures. This issued had been identified on previous inspections and remained an action on this inspection.

**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):**

No actions were required from the previous inspection.

**Findings:**

Medication management arrangements were not in line with the provider's policy.

Medication was administered by nurses in six of the seven houses in this centre. The seventh chalet was managed by an external service provider since 9 September, and this included the management and administration of medication. Inspectors found that non-nursing staff were trained in safe medication practices, but failed to identify a series of medication errors occurring daily in the centre.

These errors were identified by inspectors on the first day of inspection and brought before the attention of management. These errors were not identified prior to inspection. Inspectors issued an immediate action to the provider to ensure these practices were immediately addressed and that appropriate medication practices were put in place.

There were also inadequate medication procedures in place around the administration of night time medication. There were an insufficient number of staff working at the centre trained to administer night time medication and a nurse working in another centre were redeployed at night to administer 22.00pm medication in six houses at the centre. This resulted in medication not being administered at the prescribed time.

**Judgment:**

Non Compliant - Major

**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):**

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

**Findings:**

The statement of purpose did not accurately describe the services provided at the centre.

In the main, the statement of purpose was compliant with Schedule 1 of the regulation,



although it did not include room dimensions, accurate staffing levels and governance and management at the centre.

**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:**

Following the previous inspection management structures at the centre were reviewed. A new person in charge was working at the centre since August 2016. The person in charge showed evidence of their understanding about their role and responsibility under the regulations. Daily reviews of accidents and incidents were completed by the person in charge. However, the inspectors found concerns identified regarding safeguarding, medication management, health and safety, risk management, and fire safety had not been appropriately addressed.

The director of services was the senior person in charge of this designated centre, and inspectors found that effective management systems had not been put in place since the last inspection to ensure services were safe, appropriate to residents' needs, consistent or effectively monitored. For example, annual reviews of the care and support of residents or the six monthly unannounced visits by the provider were not made available to inspectors at the time of this inspection. Inspectors also found that the lack of managing and organising staffing distribution was having a direct negative impact on residents. For example, residents that required individualised support with daily activities were not consistently provided these as required.

An out of hours on call system in this centre was not clearly defined. The clinical nurse managers were given responsibility for out of hours calls. This role included responding to and managing all the Heath Service Executive (HSE) campus and community services associated with this centre, (which included approximately 40 houses or units) and to provide out of hour's medical and staffing information and advice to staff with their queries. However, there was no operational procedure or job description outlining the

role or responsibility of the senior person in charge.

There was no formal system in place to supervise staff and staff was not vetted in accordance with best recruitment practices and Schedule 2 requirements. Furthermore, inspectors had previously found that there was a general lack of management oversight and a lack of sufficient support, skill and resources that were contributing to these failings, and these issues had not been addressed since the last inspection.

**Judgment:**

Non Compliant - Major

**Outcome 16: Use of Resources**

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**

Use of Resources

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

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

**Findings:**

The centre had inadequate resources to meet all aspects of residents' needs.

The inspectors found there were insufficient transport resources available at the centre. Resident's daily activities were limited due to lack of accessible vehicles to transport residents to or from their day services or on social outings. In addition, access to the swimming pools was limited, and this had a negative impact for residents living in this centre.

**Judgment:**

Non Compliant - Moderate

**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:**

The number and skill mix of staff working in this centre was inadequate. The lack of consistent and familiar staffing was not managed, and this was negatively impacting daily on the operational management at the centre.

The centre had a planned and actual roster, although these were not reflective of the staff on duty during the inspection. The inspectors found that staff were frequently redeployed across the centre due to staff shortages, which impacted on residents' social activities.

Inspectors found there was no night time nursing support available at the centre resulting in nursing support being provided by another designated centre. Furthermore, the unavailability of trained staff in medication administration led to residents' not receiving medication at times when it was prescribed.

Inspectors found evidence of staff team meetings, which addressed the operations from the centre. However, these were not frequent or included all grades of staff.

Following on from the previous inspection, inspectors reviewed staff training records and found that all staff had not completed mandatory training. For example, safeguarding of vulnerable adults, positive behaviour management, fire safety, safe moving and handling practices, hand hygiene.

Inspectors reviewed Schedule 2 documents and found eight staff had not had the required vetting in accordance with the National vetting bureau ( Children and Vulnerable Persons) Act 2012.

**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):**

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

**Findings:**

Inspectors did not review all aspects of this outcome and focused on progress on actions identified on the previous inspection.

Inspectors found accidents and incident reports were not available in one unit, however, they were not consistent across the whole centre.

Schedule 5 policies were reviewed by inspectors and found that in some houses, they were not available, including a policy on the retention maintenance and destruction of records. Additionally, the inspectors found residents confidential information stored inappropriately prior to destruction.

**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:***

Thelma O'Neill  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0005313
<b>Date of Inspection:</b>	03 and 04 October 2016
<b>Date of response:</b>	22 December 2016

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

1. Residents had limited opportunities to exercise choice or control in their life.
2. There was a lack of communal and personal space and overcrowding in many chalets.

<sup>1</sup> 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:**

A de-congregation plan is active and same will facilitate reduction of number of residents residing in the chalet where residents share bedrooms. Currently 7 residents live in the chalet, 2 bedrooms are shared. Four residents from this chalet are due to transition to the community in the third quarter of 2017 and this will ensure each resident has their own bedroom. In the interim privacy curtains are in situ.

Staff ensure that residents are treated with dignity and respect at all times. PIC carries out regular unannounced visits on a regular basis to each area and observes same.

A further four residents are due to move to a community group home by first quarter of 2017.

It will be ensured that the complaints policy is displayed in all houses. An audit will be completed by a nominated team member to ensure that this policy is present in all chalets-December 2016

Workshops have taken place through Drama regarding Self Advocacy & Community Inclusion in an external theatre space in the local community—this took place over a 6 week period—2 residents attended from Woodlands Close. This process has continued over a further 6 weeks period & evaluation of same completed on 16/11/16. Further discussions regarding clear pathway with the workshop organiser on how to proceed with the next group & feedback from Residents who have already attended is to take place in January 2017. Following HIQA inspection documentation outlining the two residents involved participation in this group and photographic evidence of same was placed in their Personal Plans.

A number of referrals have been sent to National Advocacy Service for residents. National Advocacy Services informed staff that they are presently unable to meet the Individual needs for our residents within Woodlands Close following application to have an advocate appointed for each individual due to staffing constraints within their own service, contact will be made with an advice group in Sligo in order to establish an Advocacy group with the residents supported by their staff- 31st Jan 2017

One independent advocate from a National Advocacy group has confirmed that they will represent one of our individual residents in regard to her upcoming transition to a community group home-Nov 2016

Residents are consulted at all house meetings in relation to decisions regarding the service they are currently being provided with. A template to guide and record same was formulated in consultation with SALT Manager and is used throughout Woodlands Close.

A day service located in close proximity to Woodlands Close is available outside of work hours Mon-Fri to facilitate visitors due to restrictions on private space within some

chalets. In the interim while Seawinds is vacant it is also used to facilitate visitors.

Currently individuals' funds are held a local Patient Private Property Account with surplus funds held in the HSE Patient Private Property Account in Tullamore. Cregg Services is committed to the operation of the local Patient Private Property (PPP) Account in line with HSE Financial Regulations and guidelines in a manner which maximises the access of individuals to their funds. Currently each individual holds money in individual purses held in units. Additional funds can be sourced from their funds held in the local PPP account through the Accounts Office during office working hours Monday through to Friday. The very clear advice received from the Unit Manager, HSE Patients Private Property Central Unit, Tullamore is that an account cannot be opened in a financial institution in the name of a individual who cannot give informed consent to this. A 'Financial Competency Assessment and Evaluation' tool has been developed, by the Speech & Language Therapist Manager and Nursing Management, to assess each individual's support needs in relation to money management. This draft tool is currently being reviewed and it is intended that roll out of this tool commences December 2016. It is expected that this tool will also establish whether an individual can give informed consent to the opening of an account in a financial institution in their own name.

2 sessions regarding managing residents finances for staff by staff from Administration & Finance have been scheduled to take place taken place in Jan (17th and 24th) 2017

Easy read version in relation to resident's finances will be completed by end of January 2017.

Financial Competency Template is being rolled out across the service & piloted in certain areas within Woodlands Close– Speech & Language therapist manager has led out on same in collaboration with nurse managers. Same will be completed on residents who are deemed suitable within Woodlands Close.

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

**Theme:** Individualised Supports and Care

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

Residents' privacy and dignity was impaired through the use of bedroom door peep holes and there was no access to private visitors room.

**2. Action Required:**

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

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

Peep Holes which were present in bedroom doors in one chalet were blocked

immediately following inspection to prevent functioning of same and to ensure residents right to privacy and dignity-Oct 2016

A day service located in close proximity to Woodlands Close is available outside of work hours Mon-Fri to facilitate visitors due to restrictions on private space within some chalets. In the interim while Seawinds is vacant it is also used to facilitate visitors-Dec 2016

De-congregation plan is in place and same will facilitate increased space within Woodlands which will increase access to private space to meet visitors

**Proposed Timescale:** 31/12/2017

**Theme:** Individualised Supports and Care

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

There were no financial competency assessments completed for each resident to ensure the appropriate supports were available to the residents.

**3. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Financial Competency Template is being rolled out across the service & implemented in certain areas within Woodlands Close– Speech & Language therapist manager has led out on same in collaboration with nurse managers-commencing Dec 2017

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

**Theme:** Individualised Supports and Care

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

Some residents did not have adequate space to store and maintain their clothes and personal property and possessions.

**4. Action Required:**

Under Regulation 12 (3) (c) you are required to: Ensure that where necessary, each resident's linen and clothes are laundered regularly and returned to that resident.

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

De-congregation plan in place to address overcrowding within Woodlands which will lead to each resident having adequate space to store and maintain their clothes,



personal property and possessions

In the interim, vacuum bags in place to allow for rotation between summer and winter clothes and to maximise available space for residents.

**Proposed Timescale:** 31/12/2017

**Theme:** Individualised Supports and Care

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

The complaints policy was not prominently displayed in the centre.

**5. 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:**

Complaints policy will be displayed in each centre. Audit of same will be conducted by a nominated team member to ensure compliance-31st Dec 2016

**Proposed Timescale:** 31/12/2016

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

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

Some residents with support needs for communication were not assessed by a the relevant Allied Health Professional.

**6. Action Required:**

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

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

Following an Audit in Dec 2016, all 29 residents (100%) have a Communication Passport in place across Woodlands Close and preferred Communication Style templates are in each individual's personal plan identifying each residents preferred communication style. Same was completed in consultation with SALT manager.

Residents in Woodlands Close have access to a computer where assistive technology programmes have been installed by the HSE IT Dept. This is located in an area within day services however access is also available outside day service hours

2 residents have Ipads/Tablets— which are used for social interaction link with their families and leisure pursuits e.g. games and looking at photos. Skype is used by one individual to speak with her family members. Another resident is in the process of receiving an I-Pad

Two residents have digital Photo frames that they use for family memories and leisure.

Further exploration with Residents across Woodlands Close is to take place in relation to purchasing further devices if desired. This information will be ascertained from each person, with the support of their support worker, and families. The Speech & Language Therapist Manager will be support this process. Meeting scheduled for 11th Jan 2017 to explore how to progress this initiative.

**Proposed Timescale:** 31/12/2016

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

**Theme:** Individualised Supports and Care

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

There was not suitable private facilities to receive visitors in the centre.

#### **7. Action Required:**

Under Regulation 11 (3) (a) you are required to: Provide suitable communal facilities for each resident to receive visitors.

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

A day service located in close proximity to Woodlands Close is available outside of work hours Mon-Fri to facilitate visitors due to restrictions on private space within some chalets. In the interim while Seawinds is vacant it is also used to facilitate visitors at any time.

As the de-congregation plan progresses and numbers of residents within Woodlands decreases space will become available to facilitate private visitors' space.

**Proposed Timescale:** 31/12/2017

### **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:**

Residents did not have signed contracts of care and details of additional charges were not included.

**8. 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:**

The new Contracts of Care have been individualised & reviewed. The Administration & Finance department are part of this process in relation to charges for each Individual.

Families will receive a copy of the individualised contracts of care when all is completed by the end of January 2017.

Residents who have the ability will sign their own contracts of Care if they so wish.

**Proposed Timescale:** 31/01/2017

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

Inconsistencies were identified in the planning, development and review of individualised personal goals.

**9. Action Required:**

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

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

New PCP documentation is being rolled out across the service at present. There have been 2 workshops held within the service on Nov 7th and 14th to advise staff regarding the completion of this documentation. Further workshop scheduled for Mon 12th Dec.

An audit of new documentation will be completed in 3 months (March 2017) by practice development and nurse managers to assess progress of same.

This new documentation will streamline the maintenance and evaluation of personal plans

All goals will be documented using the SMART acronym as a guide

Audits of personal plans will be carried out on a regular basis by the PIC and CNM1. Schedule to be put in place for same

A working group has been established following a meeting of the ID Services Educational Strategy Planning Group on 24th Nov 2016, in collaboration with the CNME to develop a course regarding documentation for both staff nurses and care assistants. Next meeting- 27th Jan 2017

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

**Theme:** Effective Services

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

Some residents were identified as not having a comprehensive health review in excess of five years

**10. Action Required:**

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

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

Medicals recommenced within service on Tuesday 13th Sept – Schedule for Woodlands Close awaiting finalisation. 4 medicals completed on one unit within Woodlands on 2nd Dec. Further medicals scheduled for 13th Dec. All medicals for 29 residents (100%) will be completed by 28th April 2017. A rolling schedule will then be put in place to ensure all residents have annual medicals.

Database in place with GP Practise in relation to dates when people had received their last medical. Medicals are prioritised by the GP according to dates and residents needs.

**Proposed Timescale:** 28/04/2017

**Theme:** Effective Services

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

New admissions to the centre did not have a comprehensive pre-admission assessment completed.

**11. Action Required:**

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

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

All new admissions will have a comprehensive pre-admission assessment completed in

line with the Admission including Transfer, discharge and temporary absence of residents Policy 2016

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

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

Some resident personal plans were not developed and reviewed in consultation with the residents and or their families.

**12. Action Required:**

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

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

New PCP documentation is being rolled out across the service at present. There have been 2 workshops held within the service on Nov 7th and 14th to advise staff regarding the completion of this documentation. Further workshop scheduled for Mon 12th Dec. All 29 residents (100%) have personal plans in place

An audit of new documentation will be completed in 3 months (March 2017) by practice development and nurse managers to assess progress of same.

Family review forms are circulated to family members prior to review meetings seeking their input. All families are invited to attend, if this is not achievable their returned family review form is discussed at meeting

Relevant members of the residents Circle of Support are invited to the residents Annual Review

Personal goals are evaluated and set for each resident at their Annual Review

A new "My Person Centred Support Plan Review Meeting" form is being used for Annual Reviews. This forms part of the new PCP documentation

Annual reviews are ongoing and a schedule is in place for same

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

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

Resident personal plans did not consistently incorporate a multi-disciplinary approach to

facilitate an evaluation of the effectiveness of interventions

**13. Action Required:**

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

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

All relevant members of the MDT are invited to residents Annual Review Meeting, where their personal goals are evaluated and set. If members of MDT are unable to attend they are requested to submit a report which is discussed at review meeting

Personal Plans are evaluated annually or more frequently if needed. Schedule of reviews in place for any which are outstanding at present

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

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

Residents who had transitioned between services did not have transitional plans in place to guide staff on the appropriate management of resident specific risks.

**14. 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:**

All residents who are due to transition between services will have a transitional plan in place prior to transition. This will be completed in consultation with the resident and their circle of support.

Work is on-going at present in collaboration with the resident, their family member and the SALT manager, developing transitional plans for the residents who are due to transition to the community in the immediate future

Compatibility assessments are completed and remain on-going, same are reviewed regularly

**Proposed Timescale:** 31/01/2017

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

**the following respect:**

Residents were living in small overcrowded chalets, which did not meet their needs or the aims or objectives outlined in the centre's statement of purpose.

**15. Action Required:**

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

A de-congregation plan has been submitted. This outlines proposed moves to community group homes which will address overcrowding within Woodlands Close. One resident moved to a community group home in August 2016. 4 residents are due to move to a community group home by early 2017. A further 4 residents are due to transition to a community group home by 3rd quarter of 2017. One resident is due to move to a community group home by first quarter of 2017.

**Proposed Timescale:** 31/12/2017

**Theme:** Effective Services

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

Equipment and facilities were not serviced or repaired to ensure they were maintained in good working order.

**16. Action Required:**

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

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

A maintenance report system is in situ, which allows maintenance issues to be prioritised according to urgency.

Works have commenced in Woodlands Close on 2 chalets. Emergency LED lighting which has relevant certification has been installed in these 2 chalets. Free swing door closures have been installed on all fire doors in these chalets and fire resistant attic hatch doors installed. Cold water storage tanks replaced by PVC tanks. Attic insulated for fire resistance and heat maintenance. Hot water cylinders insulated and system in place to maintain hot water supply within chalet in the event of heating failure- all work due to be completed Dec 2016.

Awaiting confirmation of works to be completed on remaining chalets.

In a 2 further chalets free swinging door closures installed on 3 and 4 doors respectively-Work to be completed Dec 2016

An audit will be completed by PIC and maintenance supervisor on all chalets before end of week of 9th Jan 2017 within Woodlands to identify areas of concern and an action plan to be enacted to address these issues

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

Premises were not equipped with assistive technology aids and appliances to support and promote the full capability of the residents.

**17. Action Required:**

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

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

A meeting to be scheduled in January 2017 with staff and resident representatives, SALT Manager, Occupational Therapist, Assistive Technology Department and CNS Mobility to discuss use of assistive technology aids. Following on from this, assessments to be conducted regarding assistive technology aids and appliances.

**Proposed Timescale:** 28/02/2017

**Theme:** Effective Services

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

The requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) were not met.

**18. 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:**

A de-congregation plan has been submitted same will facilitate increased space within Woodlands which will increase access to private space to meet visitors. This outlines proposed moves to community group homes which will address overcrowding within Woodlands Close. One resident moved to a community group home in August 2016. 4 residents are due to move to a community group home by early 2017. A further 4 residents are due to transition to a community group home by 3rd quarter of 2017. One resident is due to move to a community group home by first quarter of 2017.

A day service located in close proximity to Woodlands Close is available outside of work



hours Mon-Fri to facilitate visitors due to restrictions on private space within some chalets. In the interim while Seawinds is vacant it is also used to facilitate visitors-Dec 2016

De-congregation plan in place to address overcrowding within Woodlands which will lead to each resident having adequate space to store and maintain their clothes, personal property and possessions. In the interim, vacuum bags in place to allow for rotation between summer and winter clothes and to maximise available space for residents.

A maintenance report system is in situ, which allows maintenance issues to be prioritised according to urgency

Works have commenced in Woodlands Close on 2 chalets. Emergency LED lighting which has relevant certification has been installed in these 2 areas. Free swing door closures have been installed on all fire doors in these chalets and fire resistant attic hatch doors installed. Cold water storage tanks replaced by PVC tanks. Attic insulated for fire resistance and heat maintenance. Hot water cylinders insulated and system in place to maintain hot water supply in the event of heating failure- work to be completed Dec 2016

In 2 further chalets free swinging door closures installed on 3 and 4 doors respectively- Work to be completed Dec 2016

An audit will be completed by PIC and maintenance supervisor on all chalets before end of week of 9th Jan 2017 within Woodlands to identify areas of concern and an action plan to be enacted to address these issues

**Proposed Timescale:** 31/01/2017

## **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:**

Risks identified in relation to residents compatibility to live together was not adequately managed and control measures in place were ineffective to prevent a re-occurrence of the incidents.

#### **19. Action Required:**

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

A meeting was conducted on Dec 5th with safeguarding and protection team to review the risks identified and the control measures put in place in relation to residents

compatibility to live together. Inconsistency of provision of staffing support was identified as a key causal factor in each safeguarding concern which occurred. The service has provided an assurance that correct staffing levels will be prioritised to be maintained within this area.

Behavioural support plan of resident has been reviewed by Behaviour Therapist.

Staff members supporting the resident have been supported to ensure all aspects of the safeguarding and protection plan and the Behaviour Support Plan are understood and followed consistently by all staff in this supporting role.

Staff replacement will be priority at all times to ensure no further adverse events occur.

Regular reviews of the safeguarding plan will take place and same will be submitted to the Safeguarding and Protection Team.

All safeguarding concerns will be screened under the Safeguarding of Vulnerable Persons Procedure and Guidelines and submitted to the Safeguarding and Protection Team.

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

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

Effective fire safety management systems were not in place within the designated centre.

**20. 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:**

Monthly fire drills occur regularly within Woodlands.

Learning from each evacuation are documented and shared with all staff.

PEEP plans are in place for all residents within Woodlands and an evacuation procedure is in place in all homes.

A responsible person has been identified in each house to ensure fire registers, fire safety checklists and related documentation is completed as required.

External lighting is checked to ensure same is functioning on a regular basis by staff

Unannounced walkabouts are conducted by the PIC and senior management on an ongoing basis.

Works have commenced in Woodlands Close on 2 chalets. Emergency LED lighting which has relevant certification has been installed. Free swing door closures have been installed on all fire doors. Fire resistant attic hatch doors installed. Cold water storage tanks replaced by PVC tanks. Attic insulated for fire resistance. Hot water cylinders insulated and system in place to maintain hot water supply in the event of heating failure- work to be completed Dec 2016

In 2 further chalets free swinging door closures installed on 3 and 4 doors respectively- Work to be completed Dec 2016.

PEEP training took place on Nov 8th within the service by the Fire and Safety Department. All PEEP's to be reviewed to ensure they are updated following learning from fire drills and also to ensure they are inclusive of any assistive aids required-28th Jan 2017

An updated protocol is in place in the designated centre outlining staff actions in the event of fire alarm sounding within own designated centre or other designated centre within service-Oct 2016

**Proposed Timescale:** 28/01/2017

**Theme:** Effective Services

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

The fire safety maintenance arrangements in place were not adequate in the following respects:

1. Fire resistant doors were not maintained in a manner that would ensure they would perform effectively in the event of a fire.
2. The system of in house fire safety checks required review to ensure they were carried out in adequate frequency and detail.
3. There were no adequate checks in place to prevent the accumulation of lint in the clothes dryers located within the units.

**21. Action Required:**

Under Regulation 28 (2) (b) (i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

Fire resistant doors which were not functioning correctly have been amended-Oct 2016

Automatic door closures have been installed on all fire doors in 2 chalets and on 4 doors and 3 doors respectively in 2 further chalets-Dec 2016

A recording chart has been put in situ in each chalet to record daily checks of the

accumulation of lint in the clothes dryers-Oct 2016

A fire register is in place in each chalet. One staff in each area has been appointed responsibility for ensuring same is updated accordingly

Fire drills are held during day time hours on a monthly basis in each chalet.

Deep sleep evacuations occurred in the chalets within the designated centre-Nov 2016. Going forward these will not be completed following advice from Estates Manager in Fire Safety HSE as same is felt to be an unsafe practice.

An updated protocol is in place in the designated centre outlining staff actions in the event of fire alarm sounding within own designated centre or other designated centre within service-Oct 2016

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

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

1. Adequate means of escape were not provided within the designated centre.
2. Emergency exits were difficult to open and were not connected to the main fire alarm system or the emergency release device situated beside the door.
3. The emergency lighting system had not been checked by a suitably qualified person to ensure it provided the necessary level of coverage throughout the centre and is fit for purpose.

**22. Action Required:**

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

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

Emergency exits which were difficult to open in one chalet were amended by maintenance department to ensure smooth operation-Oct 2016

Mag locks were activated on these doors, with the code for opening same displayed prominently beside door-Oct 2016

Keys were placed in break glass containers next to these doors in the event of malfunction of mag lock. All staff on duty in this chalet also carry pass keys as an additional safety measure-Oct 2016

A gate which hindered escape route from one unit was altered to ensure ease of escape-Oct 2016

Additional external lighting was installed to ensure safety on escape route from the chalet-Oct 2016

A quota has been submitted for approval for works to widen path at side of one chalet to allow for an alternative escape route in the event of a fire. Awaiting approval of funding for same

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

1. Residents' personal emergency evacuation plans (PEEPs) were not up-to-date.
2. There was not evidence that residents could be evacuated from all of the houses in this centre.

**23. Action Required:**

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

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

All PEEP's are being reviewed by staff to ensure that same are up to date and indicative of level of support and any additional aids/appliances residents may require to ensure safe escape-28th Jan 2017

PEEP and Fire Register training took place in the service for staff on 8th Nov by Fire and Safety Department

Fire training compliance for staff within Woodlands Close is currently 96%. Further fire training dates scheduled for month of Dec and there will be 100% compliance by Dec 15th

A fire register is in place in each chalet. One staff in each area has been appointed responsibility for ensuring same is updated accordingly

Fire drills are held during day time hours on a monthly basis in each chalet.

Deep sleep evacuations occurred in all chalets within the designated centre-Nov 2016. Going forward these will not be completed following advice from Estates Manager in Fire Safety HSE as same is felt to be an unsafe practice.

An updated protocol is in place in the designated centre outlining staff actions in the event of fire alarm sounding within own designated centre or other designated centre within service-Oct 2016

**Proposed Timescale:** 28/01/2017

**Theme:** Effective Services

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

Staff did not have up-to-date fire safety training.

**24. Action Required:**

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

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

Fire training compliance for staff within Woodlands Close is currently 96%. Further fire training dates scheduled for month of Dec and there will be 100% compliance by Dec 15th

**Proposed Timescale:** 15/12/2016

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Not all staff had received training in managing behaviours that challenge.

**25. 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:**

Since the inspection 4 staff have been trained in managing behaviours that challenge. Currently 65% of staff have up to date training in managing behaviours. A rolling schedule is in place to achieve 100% compliance. Dates for 2017 training will be circulated before end of Dec 2016 and a plan will be put in place to achieve compliance which will aim to be achieved by 31st May 2017

**Proposed Timescale:** 31/05/2017

**Theme:** Safe Services

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

1. The management of behavioural incidents were not reviewed and appropriate support measures had not been put in place.

2. Some residents' behavioural support plans were not adequately implemented.

**26. Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

All behavioural incidents are recorded on National Incident Management Report Forms. A manager reviews all incidents as they occur to ensure the risk of re-occurrence is minimised to an acceptable level. Some are inputted to a service data base. Forms are then stored on the residents file

On a monthly basis details of the incident are reviewed by the service Incident Review Group and learning's/further actions from same disseminated to the team for analysis and learning.

Behaviour Support plans are updated as a result of same if required

Audit to be completed of behaviour support plans in conjunction with Behaviour Therapists to ensure that resources required to ensure implementation of same are in place/available. If this is not the case action plan to be formulated to address the oversight

Psychology services within the service has increased to 32 hours per week as of Nov 21st 2016.

**Proposed Timescale:** 31/12/2016

**Theme:** Safe Services

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

Restrictive practices were not appropriately risk assessed or applied in accordance with national policy and evidence based practice.

**27. Action Required:**

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

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

All restrictive practices will be used as a last resort and for the shortest possible time

All restrictive practices will be approved by the Restrictive Practice Committee

The Restrictive Practice policy is in place and is available to all staff

Restrictive practices are notified to HIQA by PIC on Quarterly Notification forms

Restrictive practice logs in situ where required

Use of PRN medication recording charts in place in all residents medication kardex's

Psychology services have increased to 32 hours weekly within the service.

PRN Medication presentation by Consultant Psychiatrist held on 1st Nov, further training scheduled for 7th Dec.

**Proposed Timescale:** 31/12/2016

**Theme:** Safe Services

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

Residents were not protected from peer on peer abuse

**28. 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:**

All incidents of peer on peer abuse require preliminary screening under Safeguarding and Protection of Vulnerable Adults Policy, which is forwarded to Safeguarding Team for further action and recommendations. All safeguarding concerns have a management plan developed which is reviewed 2 weekly to ensure effectiveness.

Database has been developed and all safeguarding concerns are reviewed monthly. Learning shared with all staff.

In relation to one chalet where peer on peer abuse occurred a strategy meeting held on 10th and 15th Nov with input from MDT including social work and the Safeguarding and Protection Team regarding how to address the issue. Strategy in place to address same

The BSP of the individual causing the concern has been reviewed to ensure it addresses all issues of concern comprehensively.

A detailed plan is in place for the planned transition to the community with an exit strategy included if the compatibility remains a concern following the transition.

The staff team supporting this transition will undergo an induction session with input from the CNS in Behaviours, Psychology and Social Work on how best to manage the transition positively. The induction will encourage all staff to take ownership of the BSP to ensure it is a live working document.

A rotational roster will be implemented in this new community group home to support



team work and ensure consistently of care.

Meeting held 5th Dec with input from Safeguarding Team to discuss safeguarding issues within Woodlands Close. This meeting discussed the above plan relating to transitioning and ensuring safety for all residents involved.

Currently 92% of staff are trained in Protection and Safeguarding. Further training is scheduled for Dec 15th and the compliance level will increase to 94%.

**Proposed Timescale:** 28/01/2017

**Theme:** Safe Services

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

Appropriate follow up on preliminary screening actions relating to safeguarding incidences were not implemented.

**29. 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:**

Residents well being and safety is promoted at all times

All preliminary screenings are followed up with a strategy meeting

Action plans from screenings are reviewed fortnightly

All incidents are screened in line with the Protection and Safeguarding of Vulnerable Adults Policy

**Proposed Timescale:** 31/12/2016

**Theme:** Safe Services

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

Not all staff had received training in safeguarding of vulnerable adults.

**30. 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:**

Currently 92% of staff are trained in Protection and Safeguarding. Further training is scheduled for Dec 15th and the compliance level will increase to 94%

**Proposed Timescale:** 31/12/2016

### **Outcome 10. General Welfare and Development**

**Theme:** Health and Development

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

Residents who had recently transitioned between services did not receive consistent support to attend their social and daily activities.

**31. Action Required:**

Under Regulation 13 (4) (b) you are required to: Ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

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

All residents who will transition between services will have transition plans in place prior to same to ensure continuity of education, training and employment is maintained.

**Proposed Timescale:** 31/12/2016

**Theme:** Health and Development

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

Residents who do not routinely avail of day services were not supported to access opportunities for education, training and employment.

**32. 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:**

All residents who will transition between services will have transition plans in place prior to same to ensure continuity of education, training and employment is maintained.

Contact will be made by PIC with National Learning Network, RehabCare, and HSE Job Coaches for discussion regarding options available and sampling of activities-28th Jan 2017

**Proposed Timescale:** 28/02/2017

## 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:**

Residents annual medical preventative checks had not taken place, some as late as 2011.

**33. Action Required:**

Under Regulation 06 (2) (e) you are required to: Support residents to access appropriate health information both within the residential service and as available within the wider community.

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

Medicals recommenced within service on Tuesday 13th Sept – Schedule for Woodlands Close awaiting finalisation. 4 medicals completed on one unit within Woodlands on 2nd Dec. Further medicals scheduled for 13th Dec. All medicals will be completed by 28th April 2017. A rolling schedule will then be put in place to ensure all residents have annual medicals.

Database in place with GP Practise in relation to dates when people had received their last medical. Medicals are prioritised by the GP according to dates and residents needs.

**Proposed Timescale:** 28/04/2017

**Theme:** Health and Development

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

The choice of hot meals was not available to resident for the evening meal at weekends.

Provision of adequate supply and availability of snacks and refreshments was not facilitated to all residents in some houses.

**34. Action Required:**

Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

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

All chalets have access to a procurement card whereby they can purchase provisions in line with residents choice to ensure adequate supply and availability of snacks and refreshments

Snacks are prepared daily and evening meals are prepared at weekends in line with residents wishes.

Evening meals at weekends are chosen in consultation with residents wishes

All areas have access to cooking facilities

Pictorial menus in place across Woodlands Close

**Proposed Timescale:** 31/12/2016

**Theme:** Health and Development

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

Residents were not offered the opportunity to buy, prepare and cook their own meals as all meals are provided from a centralised kitchen.

**35. 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:**

All chalets have access to a procurement card whereby they can purchase provisions in line with residents choice to ensure adequate supply and availability of snacks and refreshments

Snacks are prepared daily and evening meals are prepared at weekends.

Evening meals at weekends are chosen in consultation with residents wishes

Ongoing work regarding upcoming move to community living and residents are being supported in preparation for same and partake in grocery shopping, meal preparation, accessing restaurants and café's in local community

**Proposed Timescale:** 31/12/2016

## **Outcome 12. Medication Management**

**Theme:** Health and Development

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

1. Incorrect medication dosages was administered which were not line with prescription.
2. Medication was administered without prescription.

**36. Action Required:**

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered

as prescribed to the resident for whom it is prescribed and to no other resident.

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

An immediate action was completed following the inspection whereby external agency staff members working in the chalet where, above mentioned regulatory requirement was not being met, were instructed that they must immediately commence the administration of medication in adherence to the service Policy on Administration of Medication by Care Assistants. The PIC met with these staff members and informed them of the policy and ensured understanding of same. All relevant staff read the policy in question and signed to say that they have read and understood same-Oct 2016

As per policy medications are administered only if prescribed on the service Medication cardex.

A medication audit was completed in the relevant chalet on 10th Oct by the PIC

All staff nurses within the service must complete online Medication Management course

Medications are administered in line with service Policy on Guideline for Medication Management for Nurses

A working group has been established inclusive of various disciplines to develop a new medication cardex to ensure it meets the required standards and ensures safe medication administration and management. Same has input from Practice Development, Psychiatrist, nursing staff and GP.

**Proposed Timescale:** 31/01/2017

**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 Statement of Purpose did not reflect the service provision and activities of the centre.

**37. Action Required:**

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

The Statement of Purpose will be revised to reflect the service provision and activities of the centre

Same will be updated annually or as required

**Proposed Timescale:** 31/01/2017

#### **Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

Risk management and safeguarding and protection issues were not adequately managed in the centre. For example, inadequate management of accidents or incidents, residents' documentation, supervision of care practices and evaluation of services.

**38. Action Required:**

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

A clear management structure is in place within the designated centre

Schedule of Staff Performance Management Agreements underway within centre. All staff will have a review completed by a manager by 28th April 2017.

As de-congregation occurs and new designated centres are established, the size of same will be reduced thus enhancing governance structures

PIC's within service attended PIC training on 26th and 27th October

**Proposed Timescale:** 28/04/2017

**Theme:** Leadership, Governance and Management

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

1. Management systems were not in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.
2. The annual review did not inform the quality and safety of care and support to residents.
3. The annual review did not identify areas of improvement, time frame, or action plan.
4. Areas of concern identified during previous unannounced visits by the Provider were not adequately identified, incorporated or managed through the centres risk management processes.

**39. 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:**

All incidents of peer on peer abuse require preliminary screening under Safeguarding and Protection of Vulnerable Adults Policy which is forwarded to Safeguarding Team for further action and recommendations. All safeguarding concerns have a management plan developed which is reviewed 2 weekly to ensure effectiveness.

Database has been developed and all safeguarding concerns are reviewed monthly. Learning shared with all staff.

As de-congregation occurs and new designated centres are established, the size of same will be reduced thus enhancing governance structures

All behavioural incidents are recorded on National Incident Management Report Forms. A manager reviews all incidents as they occur to ensure the risk of re-occurrence is minimised to an acceptable level. Same are inputted to a service data base. Forms are then stored on the residents file

On a monthly basis details of the incident are reviewed by the service Incident Review Group and learning's/further actions from same disseminated to the team for analysis and learning.

Risk management training is on-going across the service.

A staffing review by an external agency took place in Sept 2016. Awaiting report from same, due January 2017

Annual review of Woodlands Close completed using HIQA template-Nov 2016

Schedule of Staff Performance Management Agreements underway within centre. Same to be completed by 28th April 2017

**Proposed Timescale:** 28/04/2017

**Theme:** Leadership, Governance and Management

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

Effective arrangement were not in place to support, develop and performance manage all staff and management.

**40. Action Required:**

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

Schedule of Staff Performance Management Agreements underway within centre. Same will be completed 28th April 2017

**Proposed Timescale:** 28/04/2017

### **Outcome 16: Use of Resources**

**Theme:** Use of Resources

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

There was limited availability of accessible vehicles to transport residents to and from their day services or to avail of social outings.

**41. 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:**

Vehicles are leased if required for long distances or for a period of time, for example if residents are travelling for a holiday

In the interim if vehicle is not available taxi's are utilised. Expenses covered by HSE

**Proposed Timescale:** 31/12/2016

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

1. The number and skill mix of staff working in this centre was inadequate.
2. The lack of consistent and familiar staffing was not managed and this was negatively impacting daily on the operational management of the centre.

**42. 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:**

Staffing review has been undertaken by an external agent, report from same due Jan 2017



The use of agency staff has reduced within the service and has been replaced by care assistants. By year end 55.64 WTE will have been employed

**Proposed Timescale:** 31/12/2016

**Theme:** Responsive Workforce

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

In some units there was no actual or planned staff rota reflective of the staff working at night in the centre.

**43. Action Required:**

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

An actual and planned rota will be in place on all units for both day and night duty

Audit completed on same by night manager Dec 2016 and action plan devised to address any issues highlighted

Staff on duty to update same at beginning and end of each shift to ensure actual roster matches staff on duty

**Proposed Timescale:** 31/12/2016

**Theme:** Responsive Workforce

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

The centre did not have access to designated trained staff within the centre at night to administer medication.

**44. 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:**

A staff nurse is now located within the designated centre each night and is based within one of the chalets-Oct 2016

Staff review completed by external agent, report from same due Jan 2017

**Proposed Timescale:** 31/01/2017

**Theme:** Responsive Workforce

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

All staff did not have Garda Vetting as required by schedule two of the regulations.

**45. 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:**

Garda Vetting is being completed on remaining outstanding staff. According to the legislation as of the 29th April 2016 all staff must be Garda Vetted by the 31st December 2017. A staff has been assigned to process the forms for Cregg Services staff from January 2017 in order to comply with the legislation.

**Proposed Timescale:** 31/12/2017

**Theme:** Responsive Workforce

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

Staff did not have access to appropriate training reflective of residents needs, fire safety, safe moving and handling, safeguarding vulnerable adults, positive behaviour management and hand hygiene.

**46. 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:**

Diabetes training took place on 5th Dec. Further training scheduled for Jan 2017.

Training Needs Analysis was completed and forwarded to Centre of Nurse and Midwifery Education –Oct 2016

Educational Strategy Planning Group for ID services established by CNME with representatives from the service and PIC from Woodlands-Dec 2016. Further meeting scheduled for Jan 27th 2017

Moving and Handling Dates are in place from Occupational Health Department-these dates are in place up to 15th Dec 2016. Further dates to be forwarded for 1st Quarter of 2017 by Occupational Health Department. We are allocated 1-2 places on each training session for the service

Currently 92% of staff are trained in Protection and Safeguarding. Further training is

scheduled for Dec 15th and the compliance level will increase to 94%

Fire training compliance for staff within Woodlands Close is currently 96%. Further training scheduled and by Dec 15th there will be 100% compliance.

PEEP training took place on Nov 8th within the service by the Fire and Safety Department

Since the inspection 4 staff have been trained in managing behaviours that challenge. Currently 65% of staff have up to date training in managing behaviours. A rolling schedule is in place to achieve 100% compliance. Dates for 2017 training will be circulated before end of Dec 2016 and a plan will be put in place to achieve compliance

PRN Medication presentation by Consultant Psychiatrist held on 1st Nov, further training scheduled for 7th Dec.

PIC training for all PIC's within the service held on 26th and 27th Oct

**Proposed Timescale:** 28/02/2017

### **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Schedule five policies and procedures were not available in all units in this centre.

**47. Action Required:**

Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

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

Schedule 5 policies and procedures will be available on all units. Audit to be completed Dec 2016 to ensure compliance

**Proposed Timescale:** 13/01/2017

**Theme:** Use of Information

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

Records were not maintained in accordance with Schedule 3 requirements.

**48. Action Required:**

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

All records will be maintained in accordance with Schedule 3 requirements

Policy will be re-circulated to all staff and discussed at staff meetings-Dec 2016

**Proposed Timescale:** 31/12/2016