Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Railway View & Finnside
Centre ID:	OSV-0005488
Centre county:	Donegal
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Jacinta Lyons
Lead inspector:	Thelma O'Neill
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
26 October 2016 09:30	26 October 2016 22:00
27 October 2016 09:30	27 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 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the fourth inspection of this centre by the Health Information and Quality Authority(HIQA). This announced inspection was to assess this residential service for registration under the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
The centre is one of four designated centres in a congregated service provided by the Health Service Executive (HSE) in Donegal. The centre consisted of two houses and provided residential services to 11 adults with an intellectual disability.

During the inspection, the inspector identified significant risks to the safety and welfare of residents in this centre. As a result, the 18 outcome registration inspection was postponed and a specific safeguarding and risk management inspection was carried out instead. The provider was issued with two immediate actions during the inspection, these related to falls management and fire safety management.
Prior to this inspection, inspections had taken place in March and May of this year, and significant safeguarding and risk management issues were identified on both inspections. Subsequently, the HSE met with HIQA, and they provided assurances to HIQA that these issues would be addressed within a specific timeframe. A detailed action plan was put in place to address the areas of concern, and the inspector

reviewed the action plan as part of this inspection.

How we gathered our evidence:
During the inspection, the inspector met with ten residents at the centre. Two of the residents who could speak with the inspector told the inspector that they were happy living at the centre. They told the inspector that staff were helpful and kind to them. The inspector observed other residents to be relaxed and comfortable during the inspection. The inspector reviewed documents such as personal plans, healthcare records, policies and procedures and staff files.
During the inspection family members requested to speak with the inspector. Some relatives were complementary of the service; however, other relatives expressed their concerns about their relatives' safety and the service they were receiving.

Description of the service:
This centre comprised of two bungalows, which were part of a purpose-built complex for adults with an intellectual disability. The centre was located close to a nearby town with access to local shops and amenities. House one accommodated five residents and house two accommodated six residents. Residents living in this service were assessed as having high dependency support needs. Many residents had mobility needs and were elderly.

Overall Findings:
The inspector found that the provider had made some improvements since the previous inspections in March and May 2016.

• A new person in charge was appointed to manage this centre in September 2016.
• Some residents had transitioned to other designated centres that were not compatible with the residents living in this centre
• Some residents' individual personal plans were reviewed and updated since the last inspection.
• Mandatory training was completed for most staff working at the centre.

However, the provider continued to have non-compliances in the following areas;
• Safeguarding issues identified for some residents were not managed adequately or in a timely manner.
• Three residents had a number of falls one resulting in a serious injury and adequate falls prevention measures were not maintained.
• Improvements were also urgently required regarding fire management, risk management and medication management.

The current findings are set out in this report, and the areas of non-compliance are included within 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):
No actions were required from the previous inspection.

Findings:
The centre had an up-to-date complaints policy and information on the centre's complaints officer was prominently displayed in the centre. There was a complaint's log available in the two houses, however, they were not complete. The inspector found that complaints received by managers in the centre, were not logged in the complaints folder, as per organisational policy and procedures. In addition, the inspector found that complaint records did not show if the complainants' were satisfied with the outcome of their complaints.

The inspector reviewed residents' personal plans and nursing notes, and found that they did not consistently reflect residents' current needs, interests and capabilities. Furthermore, the inspector was not assured that all residents had frequent access to opportunities in the community similar to their peers.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
Since the previous inspection, residents who were unsuitably placed had been transitioned to another house in the campus. This had a positive impact for the residents residing in this centre.

A resident admitted to the centre had no documentation available to show that a transitional assessment had been completed prior to their admission, to assess their suitability to live in this centre. Consequently, since admission, a number of serious safeguarding incidents had occurred that had negatively impacted on the other residents living in the house.

A resident did not have their written service agreement updated following admission to the centre, to reflect the expected service level provision to be provided by the provider.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that since the last inspection there was an improvement in the assessment of health and social care needs for some residents in this designated centre. However, improvements were still required to achieve implementation of all residents' individualised health and social care assessments.

Residents' personal plans were developed based on their assessed needs. However, the plans were not being updated or reviewed consistently; for example, two residents' had

fallen four times, and their healthcare plans were not updated, and they were not reviewed by the appropriate multi-disciplinary (MDT) team member following the falls.

There was limited social support for residents who continued to live in this centre. There was limited evidence that residents utilised the local community amenities and a review of a number of residents' plans did not show how residents' individual goals were being achieved or who would support them in achieving their goals.

The provider identified a number of residents to be transitioned from this service over the next year. The Inspector reviewed the arrangements for one resident and found that while the resident was engaging in activities to support their transition, there was no written transition plan completed. The transition process had commenced, but that process was not adequate and did not provide sufficient information to ensure that the transition process was meeting the needs of the resident.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There were five actions issued following the last inspection. Four actions related to fire safety management, three actions were addressed and one was not addressed, the fifth action related to health and safety and risk management and was not complete.

The centre was equipped with suitable fire safety appliances, including fire call points, extinguishers, emergency lighting and fire exit signage. The inspector reviewed internal weekly checks conducted by centre staff, and found that these occurred in line with the centre's policies.

However, there were significant concerns found at the centre in relation to fire evacuation. The provider was required to take immediate actions to address these concerns.
1. The registered provider did not ensure that an adequate fire alarm system was in place to give warning of fires.
2. Risks identified during fire drills were not managed to ensure residents could be evacuated safety from the centre.
3. Effective fire management procedures were not in place to reflect the organisation's

fire management policies.

The inspector found that the fire alert system to call for assistance from staff in other parts of the campus had been faulty for a number of months and had not yet been repaired. Other issues were also identified in relation to the adequacy of fire doors in the centre. Some fire doors did not have intumescent strips or smoke seals and the centre and the houses used door wedges, to hold doors open fire doors, which would reduce the containment of smoke in the event of a fire.

Staff had developed personal emergency evacuation plans (PEEPS) for each resident. However, some PEEPS did not reflect the staff support that residents required if they were to be evacuated. Furthermore, residents' PEEPS were not reviewed and appropriate evacuation plans put in place to mitigate risks identified during fire drills. For example, in one incident, a resident used a walking aid during the fire drill which was found to have impeded other residents' egress from the building. The risks identified did not have adequate control measures in place for the safe evacuation for all residents.

Since the last inspection, the provider completed a review of the operational, clinical and environmental risks in the designated centre. The inspector had found that although these reviews had taken place, they were not effective in improving practices to ensure all residents' safety in the centre. For example, three residents that had previously sustained serious injuries from falls had fallen again on a number of occasions since the last inspection. Two residents had fallen four times, one of which required hospitalisation following the fall. On review, the inspector found the residents' falls prevention care plans and falls risks assessments were not updated or reviewed following the falls. Furthermore, the appropriate MDT had not been requested to review the residents' mobility following the falls.

Due to the seriousness of the risks to these residents, an immediate action was given to the provider to review all residents that were at risk of falls and update their current falls risk management plans.

The inspector found that the centre had appropriate infection-control measures in place, which reflected staff knowledge. Staff had access to hand washing and sanitizing facilities, although a review of training records found that only 66% of staff had completed training in hand hygiene.

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:
There were six actions issued following the last inspection. Two actions were addressed, and four were not complete.
Since the last inspection, the inspector found that there had been some improvement in the identification, investigation and reporting of safeguarding issues. All staff were now trained in safeguarding and safety of residents. However further improvements were required to ensure that residents were safe and that investigations into allegations of abuse were completed in a timely manner. In addition improvement was required to the assessment, management and support for behaviours that challenge within the centre.

The inspector found that the provider had taken action to improve the protection of residents from risk of abuse. There was policy and procedures were in place for the prevention, detection and response to abuse. Staff members confirmed to the inspector, they were aware of what constituted abuse and what to do in the event of an allegation, suspicion or disclosure of abuse - including whom to report any incident to. The person in charge demonstrated, to the inspector, that they were aware of their responsibilities to review incidents and identify patterns of concern.

However, there continued to be issues of concern for some residents in the centre. There were issues relating to the safeguarding of residents and the management of regular peer-to-peer altercations in the two houses. The inspector saw evidence where the individual safeguarding needs of some residents were not being met. Some residents stated that they were afraid of their peers, and were intimidated by the behaviour of some residents with whom they lived. In addition, the inspector saw records that residents were being injured from peer-to-peer altercations. A review of the management of such incidents showed a generic response recorded in some of the safeguarding plans and did not ensure adequate measures were taken to address these incidents.

Furthermore, some residents had numerous interim safeguarding plans in place at the same time, and it was unclear if all of the safeguarding risks remained or had been addressed and were now closed. The inspector found that allegations of abuse were not reported or investigated in a timely manner as per organisational policies and procedures. In addition, safeguarding plans were not robust and were not updated to reflect the current safeguarding risks in the centre.

Residents who displayed behaviours that challenge had assessments and behaviour support plans completed by behaviour support specialists. However, the inspector found that some behaviour support plans did not reflect all the behaviours of concern displayed by residents. The inspector found from reading residents daily notes that this

resulted in a lack of consistency and effectiveness in managing residents' negative behaviours. In addition, recommendations by other members of the multi-disciplinary team (MDT) were not being fully implemented for some residents. For example, members of the MDT had identified, during case reviews that some residents were living in unsuitable placements and this was negatively impacting on the resident's. However, no strategic plan was in place to show what actions were in place to address this situation.

Judgment:
Non Compliant - Major

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:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The inspector reviewed the centre's medication management arrangements, but found there were some issues in relation to the administration of medication.

The inspector found several discrepancies in the documentation and administration of medication in the centre. In addition, staff reported to the inspector that they had identified a serious medication error on day two of the inspection. The error was found to have occurred in August 2016 and related to the ordering and administration of medication to a resident who had not been prescribed the medication by the General Practitioner (GP). Furthermore, on review of the stock control audits the ordering of the wrong medication was also not identified.

Some residents in the centre were diagnosed with epilepsy and were prescribed emergency medication to be administered in the event of a seizure. The medication to be administered and procedure to follow in administering the medication was documented in an epilepsy protocol. However, on review of one resident's epilepsy care protocol, the inspector found an error where, it recommended a second sedative to be administered within five minutes of the emergency medication. The inspector requested the GP to review this protocol to ensure that this was the correct procedure to follow and was as prescribed. On review by the GP, the second sedative was discontinued by the GP.

Some residents were prescribed p.r.n (as required) medication. However, there were no

protocols to provide staff with guidance around the appropriate use of the medication and there was no review of usage of antipsychotic medication in the centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
There were two actions issued following the last inspection. One action was complete, and the other was partially complete.

The inspector found that there had been improvements in relation to the governance and management of the centre since the last inspection. The campus had been divided into four designated centres, and the provider had established a clear management structure in the centre. For example, a new person in charge was appointed to this centre in September 2016. In addition, the provider had put additional multidisciplinary supports in place to support staff in managing residents complex issues. The provider had commissioned internal and external audits of the centre and was identifying areas for continued improvement.

However, management systems continued to be inadequate to ensure safe and effective services to meet the needs of the residents. The inspector found that the actions taken following the inspection in May 2016 did not ensure that the quality and safety of care for residents had significantly improved. For example; comprehensive healthcare assessments of residents' health and social care needs were not reviewed annually. Daily activity programmes continued to be inadequate, transitional planning was not completed, and safeguarding and protection of residents were all not adequately implemented in the centre. In addition, immediate actions were required to address serious fire safety management and fall risk management at the centre.

The information required to be held at the centre in relation to the person in charge was found to be incomplete.

The inspector reviewed audit systems in operation at the centre. The first six monthly unannounced provider visit was completed recently, which identified significant improvements were required to meet regulations. The person in charge told the inspector of planned management audits in medication management, health and safety management and residents' personal plans, but these had not commenced at the time of inspection. Furthermore, the area for improvement identified in the centre's annual review on the quality of care and support for 2015 was not completed at the time of inspection.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Staffing arrangements continued not to be reflective of residents' assessed needs. Three actions from the last inspection were not complete.

The inspector observed that staff members were caring, and support was given in a timely manner to residents. However, staffing support needs were high and staffing inconsistencies, as highlighted in the previous inspection in May 2016, were still present at the centre. For example, residents required staff support in areas such as: mobility due to risk of falls, intimate care, residents that exhibited physically assaulting behaviour and increased levels of observation such as two to one support.

The person in charge told the inspector that there was adequate staff working in the centre, and staff shortages were covered by agency staff. However, a review of the staff roster showed the centre was regularly short of staff. The inspector reviewed the staffing rosters in one house over a two-week period and found that on 11 days of a 14-day roster, the required four staff members were not provided.
There was a significant reliance on agency staff in this centre, where eight out of the 19 staff were agency staff.
Furthermore, the inspector found that the staffing support provided was inconsistent

and staff were often redeployed to other centres to cover other staff absences. In addition the recommendations of a behaviour support specialist that familiar and consistent staff should be working in these houses, was not implemented despite significant risks to the residents and staff. In addition, only 10 of the staff had vetting disclosures on file.

Although the person in charge stated they were regularly available to both houses, they were not rostered on the staff duty roster, and it was unclear the level of support and supervision provided for each house in the centre. In addition, the staff rosters did not reflect the staff on duty at the time of inspection.

The inspector reviewed staff training records. Since the last inspection, all staff received training in most of the required mandatory training such as, fire safety management, safeguarding and safety, and positive behaviour support. However, not all staff completed training in hand hygiene at the centre.

The inspector reviewed staff meeting records. The inspector found staff meetings had not been facilitated at the centre since July 2016. Furthermore, although the person in charge told the inspector of proposed formal supervision meetings for staff, these were not in place at the time of inspection.

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[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005488
Date of Inspection:	26 and 27 October 2016
Date of response:	24 January 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have access to activities in line with their interests, abilities and capacity.

1. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to

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

participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
1. An individual activity schedule is in place for each resident in the designated centre which outlines the levels of support required to facilitate residents to participate in activities in accordance with their interest, capabilities and developmental needs.
2. As part of the individual schedule each resident has access to community activities and facilities.

Proposed Timescale: 06/01/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. Complaints on behalf of the residents were not recorded as per the organisational complaints procedures. Some complaints were logged in the residents' files other more serious complaints were recorded in the managers' office and there was no evidence that all complaints had been appropriately investigated and managed.

2. The details of any investigation into a complaint, the outcome of the complaint and whether the outcome was to the satisfaction of the complainant was not recorded.

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

Please state the actions you have taken or are planning to take:
1. All complaints on behalf of residents in the designated centre have been reviewed and updated.
2. Documented evidence of all complaints is available and includes;
- details of any investigations into the complaint
- the outcome of the complaint
- All actions taken following the complaint and
- The complainants' satisfaction with the outcome.

Proposed Timescale: 06/01/2017

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:

Following a new admission the provider failed to identify potential safeguarding risks and put adequate measures in place to safeguard vulnerable adults from abuse by their peers.

3. Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
1. A transition & compatibility assessment will be completed prior to any new admission to the designated centre

Proposed Timescale: With immediate effect (24th January 2017)

Proposed Timescale: 24/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A written agreement of care was not reviewed following admission to the centre.

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

Please state the actions you have taken or are planning to take:
1. A Contract of care will be agreed with each resident or their representative prior to admission to the designated centre.

Proposed Timescale: With immediate effect (24th January 2017)

Proposed Timescale: 24/01/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. There was limited social support for residents who continued to live in this centre.

2. There was little planning in relation to achieving their goals and wishes for the residents.

3. Plans that were in place were not being implemented consistently for the residents.

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

Please state the actions you have taken or are planning to take:
1. An individual activity schedule is in place for each resident in the designated centre which outlines the levels of support required to facilitate the resident's participation in activities in accordance with their interest, capabilities and developmental needs. As part of the individual schedule each resident has access to community activities and facilities. Completed 06.01.2017
2. Named Nurses will review Personal Plans on a quarterly basis, Jan, April, July & October, or more regularly if required, with the maximum participation of the resident or their representative.
3. The Person in Charge will ensure that all staff are familiar with each resident's Personal Plan and will consistently implement same

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Individual personal plans for the residents living in the centre were not being frequently reviewed nor were the effectiveness of the plans being appropriately assessed.

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

Please state the actions you have taken or are planning to take:
1. The named nurse will ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Proposed Timescale: 10/02/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
For one resident who was transitioning into alternative accommodation there was:

a) No written transition plan in place.

b) The monitoring and review of the process was found to be inadequate as it did not provide sufficient information to ensure that the transition process was meeting the needs of the resident.

7. Action Required:
Under Regulation 25 (3) (b) you are required to: Provide support for residents as they transition between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

Please state the actions you have taken or are planning to take:
1. Each resident will have a transition and compatibility assessment completed prior to admission or discharge. This will be monitored and reviewed to ensure the needs of the resident are being met.

Proposed Timescale: 28/02/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. Risks were not being adequately managed. For example, falls risk assessments had not been updated where required.

2. There was no evidence of learning from the review of accidents and incidents and effective actions had not been taken to reduce the number of incidents and accidents in the centre.

8. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
1. A Review of all falls risk assessments has been completed for residents who require same; this involved the appropriate Multidisciplinary Team members.

2. A full review of the health & safety statement, risk management and emergency procedures is currently being undertaken in the designated centre.

3. An audit of accidents and incidents will be completed on a monthly basis to identify trends arising. A corresponding action plan will be completed to ensure deficits are addressed and learning is applied.

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risks identified on completed fire drills were not reviewed and appropriate fire safety measures put in place to mitigate risks identified.

9. 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:
1. Risks identified during fire drills will be reviewed and managed to ensure residents are evacuated safely from the centre.
2. The centres Fire Evacuation Plan will be reviewed to ensure that risks identified during fire drills are managed safely.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Individualised personal support requirements were not identified in residents' personal emergency evacuation plans.

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

Please state the actions you have taken or are planning to take:
1. Personal Emergency Evacuation Plans will be updated to reflect the level of support that residents require in the event of an evacuation.

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire alert system to call for assistance from staff in other parts of the campus had been broken for a number of months and had not yet been repaired.

11. 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:
1. The centres fire alert system has been repaired and is now fully operational.

Proposed Timescale: 04/11/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Recommendations by the members of the multi-disciplinary team were not being fully implemented.

12. 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:
1. Compatibility assessments will be completed for each resident to assess suitability of the placement and the impact on other residents. These will be discussed at the Multidisciplinary safeguarding meeting. If it is determined that a resident is unsuitable for a placement a strategic plan will be put in place to outline the actions required to address this.

Proposed Timescale: 28/02/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were significant issues relating to the safeguarding of residents and management of regular peer to peer altercations in the two houses:

a) Some residents told staff that they were afraid of their peers.

b) The inspector found evidence that residents were intimidated by the behaviour issues of other residents.

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

Please state the actions you have taken or are planning to take:
1. A review of all safeguarding plans will be completed at the Multidisciplinary

safeguarding meeting to assess if the safeguarding plans are sufficiently robust and to assess if safeguarding concerns are being adequately addressed.
2. Allegations of abuse will be reported and investigated in a timely manner as per policy and procedure.
3. A review of Behaviour Support plans will be completed involving appropriate multidisciplinary team members to ensure they reflect all behaviours of concern displayed by residents and ensure a consistent and effective approach is used by staff to manage behaviours of concern.

Proposed Timescale: 28/02/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
1. Medication was supplied by the pharmacist for three months that was not prescribed by the general practitioner and the staff did not identify the medication was the incorrect medication.
2. Medication was incorrectly administered to a resident.
3. Epilepsy protocol did not reflect the medication prescribed.
4. Some residents were prescribed p.r.n. (as required) medication; however, no protocols were in place around its use.

14. 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:
1. The system for ordering and receiving medication was reviewed and strengthened. Completed 09.01.2017
2. Medication audit will be completed on a monthly basis, commenced 04.01.2017

3. A P.R.N. Protocol has been completed for residents in the centre who require the administration of P.R.N medication.

4. P.R.N Medication will be monitored on a weekly basis, commenced 21.12.2016

5. Audit of PRN medication will be completed on a monthly basis.

6. Medication will be ordered on a weekly basis, this will come into effect at the end of this month's order.

7. Each nurse in the designated centre will complete the Medication Management module on HSeland.

8. Each nurse will sign that they have read and understood the medication policies in the designated centre.

9. A Critical reflective analysis of the medication error has been completed.

Proposed Timescale: 30/01/2017

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:
All schedule 2 documents were not in place for the person in charge of the centre.

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

Please state the actions you have taken or are planning to take:
1. The Person in charge will complete Garda vetting online in conjunction with Personnel department and will maintain evidence of same for inspection.
2. The Person in charge will contact the Nursing and Midwifery board of Ireland to secure a copy of nursing qualification for personnel file.

Proposed Timescale: 31/01/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems did not ensure good governance of the centre, in relation to; fire precautions, falls risk management, medication management, and social care supports.

16. 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:
1. The named nurse will complete healthcare assessments on an annual basis.
2. An individual activity schedule is in place for each resident in the designated centre which outlines the levels of support required to facilitate resident's participation in activities in accordance with their interest, capabilities and developmental needs. As part of the individual schedule each resident has access to community activities and

facilities. Completed.
3. Each resident will have a transition and compatibility assessment completed prior to admission or discharge. This will be monitored and reviewed to ensure the needs of the resident are being met.
4. Compatibility assessments will be completed for each resident currently living in the centre to assess suitability of the placement and the impact on other residents. These will be discussed at the Multidisciplinary safeguarding meeting. If it is determined that a resident is unsuitable for a placement a strategic plan will be put in place to outline the actions required to address this.
5. A review of all safeguarding plans will be completed at the Multidisciplinary safeguarding meeting to assess if the safeguarding plans are sufficiently robust and to assess if safeguarding concerns are being adequately addressed.
6. Allegations of abuse will be reported and investigated in a timely manner as per policy and procedure.
7. A review of Behaviour Support plans will be completed involving appropriate multidisciplinary team members to ensure they reflect all behaviours of concern displayed by residents and to ensure a consistent and effective approach is used by staff to manage behaviours of concern.
8. The Fire Alarm Provider carried out a review of the fire alert system and repaired all faults. Completed 4th November 2016
9. Risks identified during fire drills will be reviewed and managed to ensure residents are evacuated safely from the centre.
10. The Centre's Fire Evacuation Plan will be reviewed to ensure that risks identified during fire drills are managed safely.
11. Personal Emergency Evacuation Plans will be updated to reflect the level of staff support that residents require if they were to be evacuated.
12. Reviews of Falls risk assessments were completed for all residents who require same; this involved the appropriate Multidisciplinary Team members.
13. A full review of the health & safety statement, risk management and emergency procedures is currently being undertaken in the designated centre.
14. The Person in charge will complete garda vetting online in conjunction with Personnel department and will maintain evidence of same for inspection.
15. The Person in charge will contact the Nursing and Midwifery board of Ireland to secure a copy of nursing qualification for personnel file.
16. The annual audit schedule will be implemented in the designated centre.
17. Actions from the annual review of the quality and safety of care and support completed March 2016 will be completed.

Proposed Timescale: 28/02/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had the required garda vetting in place.

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

Please state the actions you have taken or are planning to take:
1. Schedule 2 information and documents are in the process of completion.
2. Awaiting updated Garda vetting confirmation from the Garda vetting bureau.
3. The Person in charge will request documentary evidence from personnel department to evidence that Garda vetting is in process this will be made available for inspection.

Proposed Timescale: 28/02/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. Due to the significant reliance on agency staff there was a lack of continuity of care and support for residents.

2. In addition, staff familiar to residents were being moved to other parts of the campus to cover staff shortages in those areas.

18. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
1. Consistent permanent staff have been allocated to the designated centre.
2. Two new care staff have been appointed.
3. The agency has been contacted and informed that consistent agency staff are allocated when required.
4. A review of staff attendance at the designated centre is being undertaken and appropriate actions will be taken to promote attendance.

Proposed Timescale: 28/02/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of appropriate assessment to ascertain the supports residents required.

19. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the

statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
1. A reassessment of the needs of residents was undertaken by the Provider Nominee in conjunction with the Director of Nursing and Person in Charge to determine the number and skill mix of staff required.
2. Consistent permanent staff have been allocated to the designated centre.
3. Two new care staff have been appointed in January 2017
4. The Statement of Purpose was updated in December 2016.

Proposed Timescale: 06/01/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Rosters were inaccurate and did not reflect the staff on duty.

20. 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:
1. Planned and actual staff rosters are maintained daily reflecting staff on duty both during the day and night

Proposed Timescale: 06/01/2017

Theme: Responsive Workforce

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

21. 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:
Hand Hygiene Training will be delivered to the staff requiring same.

Proposed Timescale: 28/02/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that staff were appropriately supervised.

22. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
1. The duty roster for the Person in Charge is reflected on the roster and the Person in Charge signs the visitor book daily to reflect time spent in the designated centre to evidence the support and supervision provided in both houses. Completed.
2. The Person in Charge has a planned schedule to complete personal development plans with all staff working in the designated centre.
3. The Person in Charge will hold bi-monthly staff meetings in the designated centre.

Proposed Timescale: 28/02/2017