

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Dreenan
Centre ID:	OSV-0005490
Centre county:	Donegal
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Jacinta Lyons
Lead inspector:	Stevan Orme
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 08 February 2017 08:45 To: 08 February 2017 20:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

Following a review of compliance across the Health Service Executive (HSE) CHO Area 1, the Health Information and Quality Authority (HIQA) raised concerns with the HSE National Director, in relation to the significant and on-going levels of non-compliance in centres operated by the HSE in CHO Area 1.

The Chief Inspector of Social Services required the HSE to submit a plan to the Authority which described the actions the HSE would take, in order to improve the quality of life for residents living in the services in CHO Area 1, the overall safety of the services operated by the HSE in that area and to improve and sustain a satisfactory level of compliance across the five core outcomes of concern.

In December 2016 the HSE submitted a governance plan to HIQA. The plan described the enhanced governance and leadership arrangements and actions that the HSE intended to take by 13 June 2017, in order to improve the overall levels of compliance and quality of life for residents in CHO Area 1.

In response to this plan, HIQA has developed a regulatory programme of inspections to verify the effectiveness of this plan in improving the quality of life for resident and to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with Disabilities Regulations 2013) (hereafter called the Regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the

Standards).

How we gathered our evidence:

During the inspection, the inspector spent time with all six residents living at the centre. Residents were unable to tell the inspector about the quality of service they received at the centre, but the inspector observed that residents appeared happy and relaxed throughout the inspection. Furthermore, residents appeared comfortable with the support they received from staff.

The inspector met with four staff members during the inspection. The inspector found staff were knowledgeable on the needs of residents and supported residents in a timely and sensitive manner throughout the inspection. Support arrangements observed at the centre were in line with residents' needs. In addition, the inspector reviewed documents such as personal plans, health records, risk assessments, policies and procedures and staff personnel files.

The inspector was unable to interview the centre's person in charge as they were not available on the day of inspection.

Description of the service:

The provider had produced a document called the statement of purpose, as required by the regulations, which described the service provided. Inspectors found that the service was being provided as it was described in that document. The designated centre was part of the service provided by the Health Service Executive in Donegal. The centre provided a full-time seven day residential service to adults with a disability. The centre is located within a campus containing a further three designated centres located within a town and close to local shops and other amenities. The centre was a bungalow which comprised of six resident bedrooms. The centre was adapted in line with the needs of residents, including the provision of overhead hoists and adapted bathroom facilities for residents with mobility issues. In addition to the six bedrooms, of which one had an en-suite facility, the centre also provided three communal bathrooms including either a shower or adapted bath. Furthermore, the centre had two communal living rooms, a small visitor's room, kitchen, dining room and laundry room. In addition, the centre had a staff office with en-suite toilet.

Overall Findings:

The inspector found that residents had opportunities to access activities of their choice both within the campus grounds or local community. Throughout the inspection residents appeared happy, relaxed and comfortable with the supports they received.

The inspector found that safeguarding procedures at the centre were effective and managed in line with the organisation's policy. Furthermore, the inspector found that staff had knowledge of the safeguarding plans in place and a good understanding of what may constitute abuse and the actions to undertake abuse was suspected.

The inspector found that although not all staff had received up-to-date positive behaviour management training, staff knowledge was reflective of behaviour support

plans examined. The inspector found that although restrictive practices at the centre had been appropriately reviewed with multi-disciplinary input, there were examples of where the least restrictive practice had not been implemented.

The inspector was assured that the centre had undertaken actions to move towards regulatory compliance, although identified areas as described in the main body of the report, showed that governance and management arrangements at the centre had not addressed all areas for improvement within agreed timeframes.

Summary of regulatory compliance:

The centre was inspected against five outcomes. The inspector found moderate non-compliance in three outcomes inspected in relation to residents' personal plans accessibility, behaviour management plans, restrictive practices, staff training and personnel files. Substantial compliance was found in two outcomes relating to the centre's safety statement and governance arrangements in place at the centre.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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

Outcome 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 personal plans were regularly updated and supported residents to meet their assessed needs and achieve their personal goals.

The inspector reviewed residents' personal plans. Plans sampled included information on the supports residents' needed in areas such as maintaining a safe environment, communication, activities of daily living, personal care, behaviours of concern and sexuality. The inspector found that staff knowledge and practices during the inspection were reflective of personal plans reviewed.

Personal plans incorporated annual goals which detailed residents' preferences and needs, such as accessing increased community activities and maintaining family relationships. The personal plans included information on the steps to be undertaken to achieve the residents' annual goals and identified the staff support and expected timeframes for completion. The inspector found that three monthly evaluations were completed by staff on goal progress, including the frequency and type of community activities undertaken.

The inspector observed weekly activity sheets displayed for each resident, which were reflective of their personal goals and included activities within the designated centre, on the campus and the local community. Scheduled activities also showed that residents' were supported to participate in both group and one-to-one activities during the week, which was reflected in activity records and nursing notes reviewed by the inspector. The inspector found that although personal plans and weekly activity plans were reflective of residents' needs, they were not available in an accessible format for residents.

Personal plans were reviewed annually, and records showed an assessment of the effectiveness of agreed supports to meet residents' needs and goals. Reviews were attended by residents' families and multi-disciplinary professionals such as psychiatrists and psychologists. Where family members were invited, but unable to attend, the inspector observed that apologies were recorded and families were given the opportunity to discuss the content of the review, either prior to or after the meeting. Staff told the inspector that residents would attend their personal plan reviews; however records sampled did not consistently record residents' attendance or their level of participation in the review.

Since the previous inspection in May 2016, the inspector was informed that residents' had transferred to the centre from another designated centre within the campus. The inspector reviewed transitional plans relating to those admissions. Transitional plans included consultation with both residents' representatives and multi-disciplinary professionals such as psychiatrists and psychologists. Plans clearly showed the supports residents would require with the move to their new homes. Plans further showed that opportunities were made available for residents to visit the centre prior to admission. Documents showed that the transition process was effectively planned, with all stages of the transition assigned to a named support person with agreed timeframes for achievement.

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:

The inspector found that risk management systems at the centre were effective and ensured the safety of residents and staff.

The inspector found that the centre had an up-to-date risk management policy. The centre's risk register was up-to-date and identified risks relating to residents, staff and the centre's premises. The inspector found that the risk register and associated risk assessments identified actions to mitigate the risk, along with people responsible and the timeframes for implementing the actions. The inspector sampled actions undertaken to mitigate the effects of identified risks, and found that agreed actions had been put in place as recorded on reviewed assessments, such as introduction of additional staffing

and accessing multi-disciplinary supports. The inspector observed that staff practice and knowledge during the inspection was reflective of risk information recorded in the centre's risk register, for example residents' needs and equipment maintenance.

Risk assessments were reviewed either quarterly, bi-annually or annually dependent on their assessed severity and updated by the person in charge. Records available at the centre showed risks had been escalated to senior management, including access to multi-disciplinary supports and the subsequent actions taken.

The inspector reviewed accident and incident records maintained at the centre. Records described the event, actions taken on the day and following the event to reduce the likelihood of a reoccurrence. The inspector reviewed records relating to residents' behaviours of concern. Records showed a review of the incident and agreed changes to further support the resident, such as additional staffing. The inspector found that following the implementation of the recommended changes in support, the frequency of behaviours of concern had reduced, which was reflected in discussions with staff.

The inspector found that although risk management systems were in place, an up-to-date safety statement for the centre was not available at the time of the inspection.

The inspector reviewed staff training records and found that all staff had up-to-date manual handling training.

The inspector found that the centre's infection control practices were reflective of the provider's policy. The inspector observed information prominently displayed on hand hygiene and the disposal of waste. Furthermore, the centre provided equipment such as hand sanitisers and designated waste bins, in line with the provider's policy. However, the inspector found that not all staff had received up-to-date hand hygiene training.

The inspector reviewed fire safety arrangements at the centre. The centre was equipped with suitable fire safety equipment including fire extinguishers, a fire alarm, fire doors with magnetic release devices, fire call points, smoke detectors and emergency lighting. The inspector found that all fire equipment was regularly serviced by an external contractor, and checked weekly by staff to ensure it was in good working order. During the inspection, the inspector observed maintenance work being carried out at the centre on fire doors to ensure they were in full working order.

The inspector reviewed the centre's fire evacuation plan and found that it did not reflect staff knowledge in relation to the use of additional staff support from neighbouring centres on the campus, in the event of an evacuation. This finding was brought to the attention of the provider and the plan was subsequently revised, and put in place, prior to the end of the inspection. The inspector reviewed the revised fire evacuation plan and found that it accurately reflected arrangements in place at the centre and staff knowledge.

The inspector reviewed fire drill records which showed that evacuation drills were conducted at regular intervals, using minimal staffing at the centre and additional support from neighbouring designated centres.

The inspector examined a sample of residents' 'Personal Emergency Evacuation Plans' (PEEPs). Residents' PEEPs were up-to-date and reflected the needs of residents. Plans included evacuation arrangements for both day and night evacuations, including the use of wheelchairs or evacuation sheets. Fire drill records showed that evacuation drills had been conducted using this equipment. Staff were aware of the residents' PEEPs and their needs in the event of an evacuation.

The inspector reviewed fire safety training records. The inspector found that not all staff had received up-to-date training; however evidence of training for all staff at the centre in line with the provider's annual requirement was submitted to the inspector following the inspection.

Judgment:

Substantially Compliant

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:

Residents were safeguarded from harm and supported to manage behaviours of concern, although the use of restrictive practices in the centre required review.

The centre had an up-to-date policy on the prevention, detection and response to abuse which was reflective of staff knowledge. The inspector reviewed staff training records and found that all staff had received up-to-date training on the safeguarding of vulnerable adults. Staff were able to tell the inspector what might constitute abuse, including warning signs of possible abuse such as unexplained bruising or changes in residents' behaviour. Staff told the inspector that they would report any suspicion or allegation of abuse to the person in charge and designated safeguarding officers.

Information on the centre's safeguarding of vulnerable adults policy, including photographs of the named designated safeguarding officers, was prominently displayed at the centre.

The inspector reviewed a sample of safeguarding plans at the centre which related to residents' behaviours of concerns. Documents reviewed included referrals to the provider's Safeguarding and Protection Team following an incident and included interim safeguarding plans to protect residents affected. Plans included actions such as increased staffing for residents, accessing multi-disciplinary input and staff training to address the concern. The inspector further reviewed feedback from the safeguarding team in response to the interim plan. The recommendations from the safeguarding team were incorporated into updated resident behaviour support plans and risk assessments examined by the inspector. The inspector found that staff knowledge and practice was reflective of safeguarding plans in use on the day of inspection.

The inspector reviewed resident's behaviour support plans. Plans described the behaviour of concern and included both proactive and reactive strategies to support the resident. The inspector found that behaviour support plans and risk assessments were reviewed regularly with multi-disciplinary input, although the inspector found that one behaviour support plan had not been updated since 2014, however input from a behavioural therapist had occurred in October 2016.

Staff knowledge and practices were reflective of those plans examined, although a review of staff training records showed that not all staff at the centre had received training in positive behaviour management.

The centre maintained a register of restrictive practices. The inspector found that all restrictive practices used at the centre had been assessed prior to their introduction and involved both multi-disciplinary input and consultation with residents' families. Restrictive practices were introduced in response to identified risks for residents, as reflected in residents' personal plans and risk assessments. The inspector found that the centre had identified risks relating to residents' choking on food and being scalded by boiled water which was mitigated by the locking of the kitchen door. In addition, a resident's bedroom was locked by staff to prevent them taking clothing from their wardrobe. Following the introduction of these restrictions, the inspector did not find evidence to show that reviews had occurred to ensure that the least restrictive practices had been implemented to reduce the identified risk.

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):

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

Findings:

The centre's management systems had not addressed areas for improvement identified by the previous inspection and the provider's internal quality assurance systems.

Due to the inspection being unannounced the centre's person in charge was absent on the day of inspection. The inspection was facilitated by the centre's nurse in charge, the person in charge from a neighbouring designated centre and the provider representative.

The centre's management structure was reflective of the centre's statement of purpose and staff knowledge. The person in charge was full-time and had a regular presence in the centre as reflected in discussions with staff, meeting minutes and the centre's visitor's book. Staff told the inspector that they found the person in charge to be responsive and available as and when required. Staff further told the inspector that they found the person in charge to be approachable and confirmed that they would not have any reservations in bring concerns about the centre to the person in charge's attention. The person in charge was a qualified nurse with many years experience in working with adults with disabilities.

The inspector reviewed audit systems in place at the centre which included the monitoring of medication management, accidents and incidents and health and safety. The findings of these audits had been discussed with staff and were recorded in the centre's team meeting minutes and were reflected in staff knowledge.

The inspector was shown copies of the unannounced provider six monthly visits conducted at the centre. The inspector found that reports had been completed in 2016 and detailed findings from when the centre was part of a larger designated centre and following its reconfiguration as a standalone centre.

The inspector reviewed the centre's annual review of care and support provided which was completed when the centre was part of a larger designated centre. The inspector found that the review included analysis of the centre's compliance against the regulations and identified actions to be undertaken to address areas of improvement. The provider representative told the inspector that in partnership with the person in charge, a review of the centre as a standalone service was being completed for 2016.

The inspector found that although audit and governance arrangements were in place at the centre, they had not ensured that actions identified in the previous inspection report were fully addressed. Actions not addressed included up-to-date staff training, ensuring rosters accurately reflected staff on duty and ensuring that least restrictive practices were used at the centre.

Furthermore, the inspector found that not all actions identified through the centre's unannounced provider visits had been addressed within agreed timeframes such as staff

rosters and the introduction of formal staff supervision arrangements.

In addition, the inspector reviewed the centre's internal quality improvement plans and found that actions had not been addressed in line with agreed timeframes in areas such as:

- The introduction of formal staff supervision and personal development plans
- Development and circulation of a centre specific safety statement
- Accuracy of staff rosters

Judgment:

Substantially Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Staffing levels at the centre reflected residents' needs, although the inspector found that staff records available on the day of inspection were not fully compliant with Schedule 2 of the regulations.

The centre maintained an actual and planned roster, which reflected staffing levels, in line with the assessed needs of residents. Rosters showed that residents were supported by four to three staff members (with a nurse on duty at all times) from 08:00 to 23:00. Waking night support was provided between 23:00 and 08:00 by a nurse and health care assistant. However, the review of the roster showed, that as in the previous inspection's findings, staff were recorded on the roster for the day, but allocated to a different designated centre within the campus.

Throughout the inspection, the inspector observed residents receiving support from staff in a timely and respectful manner in line with personal plans, risk assessments and behaviour support plans. Residents appeared relaxed and happy and were supported to engage in activities both in the centre, in the campus' recreation hall and the local community on the day of inspection.

The inspector reviewed team meeting minutes. Minutes showed that the meeting was facilitated by the person in charge and showed discussions on topics such as resident needs, staff training and organisational policy. Staff told the inspector that they received informal support from the person in charge, but did not receive formal supervision and proposed 'personal development plan' meetings with staff had not commenced at the centre.

Staff were knowledgeable about the regulations proportionate to their roles and responsibilities including events which require notification to the Health Information and Quality Authority (HIQA).

The inspector reviewed a sample of four staff members' personnel files available on the day of inspection and found that they did not consistently contain all of the documents required under schedule 2 of the regulations. The inspector found that staff personnel files did not include:

- Evidence of Garda vetting
- Employment references
- Employment contracts
- Employment histories
- Photographic identification

Judgment:

Non Compliant - Moderate

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:

Stevan Orme
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005490
Date of Inspection:	08 February 2017
Date of response:	07 March 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 05: Social Care Needs

Theme: Effective Services

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

Annual review records did not consistently show residents' attendance or level of participation.

1. Action Required:

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

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

conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

- The template used to record annual reviews has been amended to ensure residents attendance and level of participation is documented.
- The rationale for this has been communicated to all relevant staff.

Proposed Timescale: Completed 24th February 2017

Proposed Timescale: 24/02/2017

Theme: Effective Services

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

Personal plans and weekly activity schedules were not available to residents in an accessible format.

2. Action Required:

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

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

The Person in Charge will review the personal plans and weekly activity schedules currently in place to ensure they are in an accessible format suitable to each residents' individual needs.

Proposed Timescale: 14/04/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The centre did not have an up-to-date safety statement available.

3. 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. The service safety statement has been added to the site specific safety folder and

circulated for all staff to read and sign. 24.02.2017

2. The Person in Charge will complete an audit to ensure all staff have read and signed same by 28.04.2017

Proposed Timescale: (1). 24th February 2017 completed (2) 28th April 2017

Proposed Timescale: 28/04/2017

Theme: Effective Services

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

The inspector found that staff at the centre did not all have up-to-date hand hygiene training

4. Action Required:

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

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

5 staff to complete hand hygiene training, 3 will complete training by 10th March 2017
PIC will ensure the remaining 2 staff will complete training when they return from long term leave.

Proposed Timescale: 10/03/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff at the centre had not all received positive behaviour management training.

5. 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:

One member of staff who required training completed same on 10th February 2017.

Proposed Timescale: completed 10th February 2017

Proposed Timescale: 10/02/2017

Theme: Safe Services

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

Restrictive practices in use at the centre had not been reviewed to ensure they were the least restrictive available.

6. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

The restrictive practice referred to in the report has been reviewed and alternative measures which are less restrictive have been agreed. Prior to implementation the Person in Charge will discuss changes with residents at residents' weekly meeting, bring to the attention of all staff and ensure written protocols are in place to guide staff.

Proposed Timescale: 17/03/2017

Theme: Safe Services

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

The inspector found that a behaviour support plan had not been updated since 2014.

7. 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:

A therapeutic intervention plan developed by the Multidisciplinary team and implemented on the 20th of October 2016 replaced the behaviour support plan viewed, the behaviour support plan dated 2014 has been removed and archived.

Proposed Timescale: Completed 9th February 2017

Proposed Timescale: 09/02/2017

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:

Governance and management arrangements at the centre had not ensured that the findings from the previous inspection report, the unannounced provider visits and the internal quality improvement plan were fully addressed in line with agreed timeframes.

8. 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 outstanding action from the unannounced provider visit in relation to personal development plans for staff has commenced and will be completed by 10th March 2017.

Three actions remain outstanding from the internal quality improvement plan:

2a. Review of person centred plan and care plan documentation –a review has taken place and the updated documentation to be implemented has been circulated to Directors of Nursing and Area Coordinators for feedback prior to approval.

2b. Contracts of care have been reviewed by the Business Manager with legal input. Agreed template is now in place. Contracts of care will be reviewed as and when necessary.

2c. The service safety statement has been added to the site specific safety folder and circulated to all staff to read and sign. 24.02.2017. The Person in Charge will complete an audit to ensure all staff have read and signed same by 28.04.2017

Proposed Timescale: 1. 10th March 2017 2a. March 31st 2017 2c. 28th April 2017

Proposed Timescale: 28/04/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The centre's roster was not reflective of staff on duty on the day of inspection.

9. 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. The Person in Charge has discussed and reinforced this will all nurses responsible for updating the centre's roster on 13th February 2017. This was also an agenda item at the centre's local governance meeting held 22nd February 2017.

The Person in Charge will complete random checks to ensure the roster accurately reflects the staff on duty completed 13th February 2017 and will be ongoing.

2. The responsibility for completing off duties will be assigned to each of the PICS in the designated centres

Proposed Timescale: Completed 31 March 2017

Proposed Timescale: 31/03/2017

Theme: Responsive Workforce

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

Staff personnel records reviewed did not contain all documents required under schedule 2 of the regulations.

10. 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:

The Person in Charge has contact the Human Resource Manager to obtain outstanding documents for staff files. All staff commenced the Garda vetting process in September 2016 awaiting letters to confirm clearance. The time frame for Garda vetting to be processed can take several months.

Proposed Timescale: 31/05/2017

Theme: Responsive Workforce

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

Formal supervision arrangements for staff were not in place at the centre.

11. 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:

Personal development plans for staff have commenced and will be completed by 10th March 2017.

Proposed Timescale: 10/03/2017