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

<table>
<thead>
<tr>
<th>Centre name</th>
<th>Oakvale</th>
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<tbody>
<tr>
<td>Centre ID</td>
<td>OSV-0002463</td>
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<tr>
<td>Centre county</td>
<td>Cork</td>
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<tr>
<td>Type of centre</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider</td>
<td>Health Service Executive</td>
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<tr>
<td>Lead inspector</td>
<td>Kieran Murphy</td>
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<tr>
<td>Support inspector(s)</td>
<td>Caitriona Twomey</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection</td>
<td>26</td>
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<td>Number of vacancies on the date of inspection</td>
<td>4</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

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

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<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>18 January 2018 11:00</td>
<td>18 January 2018 18:30</td>
</tr>
<tr>
<td>19 January 2018 10:30</td>
<td>19 January 2018 16:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
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<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<td>Outcome 02: Communication</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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**Summary of findings from this inspection**

Background to the inspection

This was the fifth inspection of this centre which was managed by the Health Service Executive (HSE). In November 2015, the Health Information and Quality Authority (HIQA) had applied to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities, under the auspices of the provider; this centre comprised one of the three centres identified in the district court order. The provider consented to the application and the court applied the conditions. This report relates to an unannounced inspection undertaken to monitor compliance and identify if progress had been sustained since the most recent inspection undertaken in December 2016.

Description of the service

The centre was based in a campus style environment with two other designated centres on site and could provide a home to 30 residents in five separate bungalows that were connected by a link corridor. As part of the HSE commitment to facilitate the transition of residents from the centres on campus to more appropriate community-based living, Oakvale had seen five residents moving out to the community with three more residents moving into Oakvale from another centre.

A number of residents in the centre had increasingly complex healthcare needs and a
high level of support needs. As a result the HSE had undertaken significant renovations in this centre including the widening of bedroom doors in one of the bungalows and the installation of ceiling track hoists in all bedroom and bathroom areas of another two bungalows. These works also included a reconfiguration of bedroom layout to facilitate the admission of residents with higher support needs.

A new person in charge had been appointed in 2017 who was suitably qualified and experienced to discharge their role.

How we gathered our evidence
Inspectors met with 20 residents living in the centre and over the course of the two days of the inspection there had been a wide range of activities both within the centre and in the community for residents. Any staff member spoken with was very committed to residents and supporting residents to have a good quality of life. All interactions between staff and residents over the course of the two days of the inspection were respectful and it was clear that staff had an in-depth knowledge of residents’ preferences.

Inspectors also observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

Overall judgment of our findings
Overall, there was evidence of good practice. Residents were being supported to age with dignity and in particular, residents received support at the end of their lives which met their physical, emotional and spiritual needs. Over the course of the two days of the inspection there was a wide range of activities both within the centre and in the community for residents.

However, of the seven outcomes inspected one was at the level of major non-compliance:
- Appropriate action was not being taken in response to all incidents of alleged, suspected or confirmed abuse of residents. There was evidence that this was influenced by the implementation of a guidance document that was not consistent with national policy and the regulations. There were also a number of restrictions in the centre that were not recognised as such by the service (Outcome 8: Safeguarding and Safety).

Improvement was also required in relation to:
- Ensuring that each resident’s privacy and dignity was respected in relation to their personal and living space (Outcome 1: Privacy).
- All assistance and support being available for residents to communicate (Outcome 2: Communication).
- Some improvement was needed in the care planning process (Outcome 5: Social Care Needs).
- Residents did not have access to required allied health professionals and so not all healthcare needs could be met (Outcome 11: Healthcare).
- Some improvement was required in relation to medicines management practices (Outcome 12: Medicines Management).
- Some improvement was required to the systems in place to ensure the service was
effectively monitored (Outcome 14: Governance).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
Some practices did not ensure that each resident’s privacy and dignity was respected in relation to their personal and living space.

Inspectors observed that without exception, all interactions between staff and residents over the course of the two days of the inspection were respectful and it was clear that staff had an in-depth knowledge of residents’ preferences.

While visiting residents’ bungalows, it was noted by inspectors that some residents’ bedroom doors had clear glass viewing panels in the door which provided a clear view into residents’ bedrooms. Some residents had requested a roller blind for these viewing panels to respect their privacy. While there were healthcare concerns for some residents to validate the use of these viewing panels, for other residents there were no safety, or other reasons, either documented or outlined during the inspection for the use of viewing panels. In addition, it was observed that communication boards in some kitchen areas had personal information from residents’ care plans written on them. These practices did not ensure that each resident’s privacy and dignity was respected in relation to their personal and living space.

It was found that original healthcare appointment records were being filed in the house communication diary. While these appointments were also being documented in the progress daily notes for the resident, they did not always inform a care plan in residents’ healthcare records. This method of communication also did not adequately protect residents’ privacy.
The inspectors noted that residents retained control over their own possessions and most residents had adequate wardrobe space in their own spacious bedroom which was decorated in a manner that reflected each resident’s individuality. It was noted that where renovations had been undertaken in the building, the amount of storage space available to some residents had been reduced.

Each bungalow had a separate visitors’ room where residents could meet with friends and family in private. However, inspectors noted that in one of the bungalows not all residents could access the visitors’ room. The person in charge said that this access issue was to be rectified in the next renovation works. In addition, inspectors observed that one of the visitors’ rooms was being used to store equipment and this was immediately removed by the person in charge.

In 2017 the service had requested feedback from families and residents on the quality of care being provided. Five families had provided feedback and in general the feedback was positive and in particular the care being provided by staff was praised. A meeting was held with eight residents and again the feedback was that the staff “were doing a great job”.

The organisation had a complaints policy and easy-to-read versions were displayed throughout the centre. The complaints policy identified a nominated person to manage complaints in the organisation. Residents also had access to advocacy support. Documentation was available with names and contact numbers for residents and or their families who wished to use this service. Each resident had a named “key worker” who said that they supported the resident or advocated on behalf of the resident as required.

**Judgment:**
Substantially Compliant

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**Outcome 02: Communication**

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
There was a policy on communication and each resident had a care plan in relation to communication needs. However, improvement was required to ensure that all assistance and support was available for residents to communicate.

Staff were observed over the course of the inspection to support residents to communicate. Inspectors reviewed residents' personal plans and found that where
residents had communication needs, this was captured in personal plans. Some residents with specific communication needs were using computerised tablets to support them to communicate, as recommended by the service’s occupational therapy department.

It was noted that some residents in particular had the need for increasing supports in relation to communication and the service had been very responsive to their changing needs including facilitating assessments from an occupational therapist and external expertise. The service had also arranged for out-patient reviews by consultant specialists. Many of the recommendations had been implemented and staff were aware of the recommendations.

In the six monthly review of quality and safety of care in the centre in December 2017, the service recorded that there was “a recognised shortcoming in the area of communication across the centre” as residents did not have access to a speech and language service to support residents, communication needs. It was noted that the service did have access to a speech and language therapist but this was via a private company and related to supporting residents with swallowing difficulties. As an example, on this inspection it was found that one of the resident’s communication needs was not being met as not all staff had been trained to communicate with this resident. Inspectors noted that communication supports had started with an external expert and at the most recent multidisciplinary team meeting it had been recommended that a speech and language therapist would be engaged to teach staff how to communicate with this resident.

Inspectors observed communication boards throughout the centre which contained pictures of what was for dinner that night and also there was a picture rota of which staff were on duty. However, photos of some staff were not available and so the communication board was not fully completed.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

**Findings:**
Residents were supported to transition between services. Each resident's assessed needs were set out in an individualised personal plan that reflected their needs, interests and capacities but some improvement was needed in the care planning process.

During 2017, five residents from Oakvale had moved to more appropriate community-based housing. The project manager for the transition of residents to the community based model of service was present during the inspection and outlined how the transition for these residents had taken place in a planned and safe manner. In particular, the HSE had appointed four community transition coordinators to support residents during the process of moving.

Inspectors noted that in the feedback sought from families by the service in December 2017, it had been commented that families had not received direct communication from the service regarding proposed moves to the community for current residents. The project manager outlined that more residents had planned to move from Oakvale to the community during 2017 but unforeseen delays had arisen around acquiring suitable premises. However, for each resident moving in 2018, a community transition coordinator was in place to link the resident to all necessary services and supports and for ensuring that all services and supports were in place prior to the transition.

A further three residents had been admitted to Oakvale from other centres on the campus in 2017. For each of these residents there had been a transition plan put in place with visits to Oakvale in the lead up to the move. Inspectors met with two of the residents who had moved and they appeared very happy with their move. It was noted that there had been one further admission to Oakvale during 2017. However, the impact of this admission on the other residents had resulted in an alternative placement being found.

Inspectors reviewed a sample of resident records. For each resident there were two sets of records, a file for medical and healthcare records that included records of reviews by medical doctors, consultant letters and blood test results and the personal file that contained the care plans and person-centred planning reviews.

In relation to healthcare needs, assessments and care plans were in place for identified healthcare needs. There was evidence of input from the relevant healthcare professionals in relation to residents' needs and in particular a meeting, as required, of the multidisciplinary team to discuss each resident's needs. However, the care plan was not always being updated to reflect current treatment recommendations from healthcare professionals. This issue had also been identified by the service themselves in their own review of quality of care in December 2017.

In relation to residents having access to social activities and social opportunities; over the course of the two days of the inspection there had been a wide range of activities both within the centre and in the community for residents. However, it was noted that neither of the two vehicles available to residents could facilitate access for all and this afforded limited opportunity to some residents to access events in the community. The
service had made a submission for additional funding for transport to resolve this issue and in the meantime the service was paying for the use of accessible taxis.

**Judgment:**
Substantially Compliant

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

**Findings:**

It was identified during the inspection that appropriate action was not taken in response to all incidents of alleged, suspected or confirmed abuse of residents. There was evidence that this was influenced by the implementation of a guidance document that was not consistent with national policy and the regulations. There were also a number of restrictions in the centre that were not recognised as such by the provider.

It is a requirement of the regulations that all serious adverse incidents, including safeguarding issues are reported to HIQA. Inspectors reviewed records of incidents that occurred in the centre in 2017. There was evidence that the person in charge had reviewed each of these incident reports and it was noted that there had been a marked reduction in the number of such incidents when compared with the previous year. However, 39 of the records detailed instances of alleged, suspected or confirmed physical abuse between residents in the centre but none had been notified to HIQA.

The person in charge outlined that reviews of incidents were completed with reference to an ‘Adult Protection Thresholds Guide’ document available in the centre. This document was not dated or signed. Inspectors identified that the information in this guide was not consistent with the national safeguarding policy. As a result, screening and investigations into any incidents, allegations or suspicions of abuse were not completed as required.

The person in charge told inspectors that incidents were discussed every weekday morning at a safeguarding meeting with others in a management role in the organisation, including the designated officer. Inspectors reviewed incidents that occurred in two bungalows over two separate months. It was identified that in one
bungalow, over one month, there were six reports of peer to peer abuse. In the other, there were five incidents documented over a separate month. Screening had been completed for the 11 incidents on a cumulative basis but each one had not been separately screened as required.

Inspectors also reviewed the corresponding safeguarding minutes for the month that six incidents occurred. According to the minutes, two of the six incidents were not discussed; three were discussed, however the designated officer was not present at those meetings. The final incident was discussed at a safeguarding meeting, in the presence of the designated officer; however, the notes indicated that the incident was targeted at a staff member. During the inspection, a staff member working in the bungalow confirmed to inspectors that the person affected by this incident was a resident, not a staff member.

Inspectors noted that where incidents were discussed at safeguarding meetings there were follow-up actions were identified, such as staff to increase supervision of the resident in question or to discuss behaviour support plans at handover.

Inspectors reviewed the personal plan of the resident involved in six peer assaults over one month. There was evidence that input from multidisciplinary professionals was requested and provided to support this resident, others living in that part of the centre, and the staff team. A mental health support plan was developed and recordings completed to monitor its effectiveness. The person’s individual risk assessment was revised and a safeguarding plan developed and subsequently revised. The designated officer’s signature was noted on the safeguarding plan.

The provider is obliged to notify HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). There was no register of restrictive practices in the centre. There was a rights review committee in the organisation that reviewed restrictive procedures and that met twice monthly. While it was evident from speaking with the staff team that the number of routine restrictions, and the use of some emergency restraints, had reduced over the previous two years there were still many restrictions evident in the centre that had not been identified as restrictions and had not been considered by the rights review committee. In addition, not all of these were notified to HIQA, as is required by the regulations.

There was also evidence in some parts of the centre that double restrictions were in place to address the same issue. For example, an external door was fitted with an alarm to alert staff should a resident go outside. However on the day of inspection, inspectors found this door was also locked.

Inspectors reviewed training records in the centre. It was identified by the provider that 32 out of 69 staff required training in training on how to respond to behaviour that is challenging, including de-escalation and intervention techniques. These staff members were scheduled to attend training in late January or February 2018. In addition, the provider had arranged for staff to attend training in positive behaviour support in February 2018. The provider had also identified that 10 out of 69 staff required safeguarding training. No date was confirmed for this training to take place.
During 2017, HIQA had received unsolicited information and had asked the service provider to investigate. An inspector reviewed documentation in relation to the unsolicited information and was satisfied that the issues raised had been dealt with appropriately by the person in charge.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Residents were being supported to achieve and enjoy the best possible health. Residents were supported to age with dignity and respect. In particular, residents received support at the end of their lives which met their physical, emotional and spiritual needs. However, residents did not have access to required allied health professionals and so not all healthcare needs could be met.

Care plans identified the spiritual needs of residents in particular, for their care at end of life. There was also care planning in relation to pain management and support from the palliative care team, as required. There was evidence of appropriate assessment and review of residents at end of life by the general practitioner (GP). The records also indicated that the community palliative care team was available both by visiting the resident and via telephone for advice.

In the sample of resident healthcare records seen by inspectors, each resident had access to a GP who did “rounds” in the centre. Each resident had an annual health screening with the GP and all recommendations from these screenings were being implemented.

There was evidence of good access to specialist care in psychiatry, with a consultant psychiatrist available to residents as required. The GP requested review of residents’ healthcare needs by consultant specialists as required.

There was evidence that residents could access occupational therapy as required. However, on inspection, it was identified that residents did not have access to required allied health professionals and so not all their healthcare needs could be met. The centre risk register, which was a document that identified all hazards the centre was actively managing, identified also that access to psychology support, speech and language
therapy and social work was required. In addition the service had identified this issue in its six monthly review of quality and safety of care in the centre.

Dinner was prepared off site and was delivered to the centre in thermally insulated trolleys. Staff adapted the meals to accommodate individual residents’ food preferences or dietary requirements. Due to some residents’ dependency levels staff assisted these residents with their meals. Staff were observed assisting residents in a sensitive manner and engaged in a positive way with residents throughout the meal.

**Judgment:**
Non Compliant - Moderate

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**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

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

**Findings:**
Some improvement was required in relation to medicines management practices.

A number of residents required medicine for the management of pain. These medicines were on schedule 2 of the Misuse of Drugs Acts (commonly referred to as controlled drugs/schedule 2 drugs). There were appropriate security systems in place for storing this medicine. In addition, the required monitoring and checking of the stock balance of these medicines was being undertaken.

A sample of medicine prescription and administration records was reviewed by an inspector. Medicine prescriptions were written by a medical doctor. Medicine administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. However, the inspector identified an administration record sheet was left blank with no reason recorded and so it could not be demonstrated that medicines were administered as prescribed. A similar issue had been identified on the previous inspection.

**Judgment:**
Substantially Compliant

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**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 was managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service. However, some improvement was required to the systems in place to ensure the service was effectively monitored.

The person in charge was a registered nurse with a degree and a Masters' qualification in nursing and had been appointed to the role in March 2017.

The person in charge was supported by management arrangements that included the representative of the HSE, who was the project manager for the transition of residents to community living, and the acting director of nursing. In the centre there was a senior clinical nurse manager (CNM II) and two junior clinical nurse managers (CNM I). The two CNM I grades were based in one of the five bungalows only and worked as part of the roster in one bungalow only. The two CNMI grades were supernumerary on the weekend. The person in charge outlined that at times he or the CNM II had to undertake medicine administration if no nursing staff were available.

Inspectors noted that while an annual review of the quality and safety of care of the service for 2017 had been completed in January 2018, there had not been an annual review for the year 2016. The review for 2017 had looked at six care and support 'themes' namely:
- Supports and care for residents
- Effective services
- Safe services
- Health and wellbeing
- Governance
- Workforce

The provider had ensured that unannounced visits to each house within the designated centre had been completed; the first in July 2017 and the second in December 2017. Inspectors reviewed the report arising from such visits and found that visits required development in order to meet the requirements of the regulations, in particular only one issue, namely staff training in relation to restrictions, had been identified in relation to safeguarding and restrictive interventions.
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:

Kieran Murphy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

Centre name: A designated centre for people with disabilities operated by Health Service Executive
Centre ID: OSV-0002463
Date of Inspection: 18 January 2018
Date of response: 01 March 2018

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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In one of the bungalows not all residents could access the visitors’ room.

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

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The service completed door widening and addition of ceiling hoists in 2017 in two of the bungalows in Oakvale to accommodate the changing needs of the residents in the context of the residents with high dependency care needs who will move from St Raphael’s Centre in 2018 as well as existing residents. The service continues to work with Estates Department in terms of identifying capital requirements to carry out similar works in bungalows where residents require such changes to their living space to best support their needs. This will address door widening for the bungalow in question.

Proposed Timescale: 30/09/2018
Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were a number of practices which did not ensure that each resident’s privacy and dignity was respected in relation to their personal and living space.

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

Please state the actions you have taken or are planning to take:
Works have been commenced to apply binding to the clear glass in question to greater provide for privacy for the residents. In relation the practice of putting personal on communication boards and diaries, this practice has ceased and this has been communicated to staff

Proposed Timescale: 16/03/2018

Outcome 02: Communication
Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Not all residents communication needs were being met.

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

Please state the actions you have taken or are planning to take:
The need for on-site access to SALT services has been highlighted on the risk register
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:
Healthcare plans were not always being updated to reflect current treatment recommendations from healthcare professionals.

4. 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:
The report indicates that on the day of inspection it was found that in the bungalow diaries that there were hospital appointments kept on the relevant dates/pages. It also indicated that the plans were not always being updated to reflect current treatment recommendations from health care professionals. From the 16/03/18 this practice will cease. A new “Support Plan Update” page will be implemented behind each care plan and details of appointments and information pertinent to each support plan will be entered into these pages as it occurs. This will be implemented by the 16/03/18.

Proposed Timescale: From the 16/03/18 a new “Support Plan Update” page will be implemented behind each care plan and details of appointments and information pertinent to each support plan will be entered into these pages as it occurs. This will be implemented by the 16/03/18.

Proposed Timescale: 16/03/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Restrictive procedures were not being implemented in line with best practice.

5. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.
Please state the actions you have taken or are planning to take:
As stated above the service provider has made plans to conduct an audit of restrictive practices in the designated centre. This audit will be conducted by suitably qualified persons who are external to Oakvale. The findings of this audit will then be considered. Where it is identified that rights restrictions have been overlooked or have become customary practice a new application will be made to the centres local rights review committee. The rights review committee will then consider if a less restrictive measure could be employed to safeguard the residents in our care. All recommendations from the rights review committee will be implemented is a timely manner.

The service also plans to implement a process whereby each bungalow will conduct an audit and report on a monthly basis in relation to restrictions. This will examine the number of restraints used in the previous month in relation to physical, chemical or environmental restraints. This will be examined by the PIC and other local managers at the monthly local managers meeting. Where necessary PRN protocols will be revised and submissions will be mad to the local rights review committee. This will also serve to heighten awareness amongst staff on the ground of the types of restraints that are being used.

Proposed Timescale: 30/03/18 for audit of rights restrictions to be completed by people external to Oakvale. 20/04/18 for all new applications to be submitted to the local rights review committee. 04/05/18 for all new recommendations from rights review committee to be implemented.

The audit of bungalows restrictive practices will be implemented by 31/03/18. This will then be reviewed at the local managers meeting which usually takes place on the first week of every month.

Proposed Timescale: 31/03/2018
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence in the centre that the least restrictive procedure, for the shortest duration necessary, is used.

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:
In response to these findings the service provider has made plans to conduct an audit of restrictive practices in the designated centre. This audit will be conducted by suitably qualified persons who are external to Oakvale so as to ensure objectivity. The findings
of this audit will then be considered. Where it is identified that rights restrictions have been overlooked or have become customary practice a new application will be made to the centres local rights review committee. The rights review committee will then consider if a less restrictive measure could be employed to safeguard the residents in our care. All recommendations from the rights review committee will be implemented in a timely manner.

Proposed Timescale: 30/03/18 for audit of rights restrictions to be completed by people external to Oakvale. 20/04/18 for all new applications to be submitted to the local rights review committee. 04/05/18 for all new recommendations from rights review committee to be implemented.

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

Investigations were not initiated in relation to every incident, allegation or suspicion of abuse of residents in the centre.

**7. Action Required:**
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**
Following the date of the end of the inspection on the 19/01/18 the service has reviewed and discontinued the use of the ‘Adult Protection Thresholds Guide’ document. Since then the service has reported all incidents of peer to peer abuse to HIQA in line with the regulatory requirement. The service has also been screening all incidents and reporting same to the HSE safeguarding team. Where indicated safeguarding plans are being drawn up and implemented in line with HSE policy. At local level the senior managers within the service meet to discuss all incidents which have occurred within the designated centre on each weekday morning. Safeguarding plans and follow up to each incident is discussed where necessary at these meetings. A working group will be established to review current processes and make recommendations as appropriate.

Proposed Timescale: In place since the 19/01/18 and working group to be established by 31st March 2018.

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff had not received appropriate training in relation to safeguarding residents.

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

**Please state the actions you have taken or are planning to take:**
The 10 staff identified as not having received safeguarding training have been put forward to receive this training as a priority.

**Proposed Timescale:** 31/05/2018

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents did not have access to required allied health professionals and so all their healthcare needs could not be met.

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

**Please state the actions you have taken or are planning to take:**
Speech and Language Therapist post was approved in 2017 and is being processed through the National Recruitment Service.

**Proposed Timescale:** 30/06/2018

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**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:**
An administration record sheet was left blank with no reason recorded and so it could not be demonstrated that medicines were administered as prescribed.

10. **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:
At the last HIQA inspection it was highlighted that there was shortcomings in relation to medication management practices within the designated centre. Since then measures have been implemented to safeguard residents in relation to medication management practices. These included the implementation of blister pack medications, double locked cabinet for DDA medications, documentation error recording booklets, more robust medication audits, checking of medications on receipt from pharmacy and new prescriptions and weekly counting of loose medications. The medication management policy has been updated to reflect these changes. The service plans to hold a nurses meeting to discuss the recent changes which have been outlined. At this meeting the protocols around what to do when it is noted that a medication is not signed for, when it is noted that a medication has not been given and still in blister pack without the relevant code being entered on the medication cardex will be specifically be discussed. The PIC and members of the management team will continue to carry out audits around medication practices and monitor same.

Proposed Timescale: A nurses meeting will take place before the 31/03/18 and these issues will be discussed and actions developed and implemented.

Proposed Timescale: 31/03/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some improvement was required to the systems in place to ensure the service was effectively monitored.

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

Please state the actions you have taken or are planning to take:
The service, on foot of previous HIQA inspection recommendations, put arrangements in place to make CNM1s supernumerary at weekends. Ongoing workforce planning for 2018 has taken consideration of the need to have supernumerary CNM1s within Oakvale. However this workforce plan must also take the wider service into consideration. Additionally, movement of staff is linked to the closure of St. Raphaels Centre and the movement of resources across the service which will result from this closure.

Proposed Timescale: 30/09/2018