

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Lifford Accommodation
Centre ID:	OSV-0002678
Centre county:	Donegal
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Lead inspector:	Thelma O'Neill
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:	2

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: 25 January 2018 09:00 To: 25 January 2018 17:00

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 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Summary of findings from this inspection:

The last inspection of this centre took place on 8 and 9 December 2015. The centre was registered to operate as a designated centre with eight beds. On this inspection, 12 outcomes were inspected and five of these outcomes were found to be compliant or substantially compliant and seven outcomes were found to be non-complaint. In addition, the inspector reviewed eight actions required from the last inspection and found that six actions were not addressed. The inspector found that there was an absence of effective oversight by the provider of the organisational and operational management in the centre to ensure a safe quality service for residents.

How we gathered our evidence:

During the inspection, the inspector met with the six residents and four staff members. One resident showed the inspector around their house and all the residents told the inspector they were happy living in the centre. There were two vacancies at the time of inspection. The inspector observed practices and reviewed the documentation including personal plans, medication records, accident and

incident reports, policies, procedures, staff training records and staff rotas.

Description of the service:

This centre provided semi-independent support for up to eight residents with an intellectual disability. It comprised of two semi-detached houses and was located in a modern housing estate in a small village in Co. Donegal. Both houses were comfortable, well maintained and decorated to a good standard. Each house had appropriate communal areas and each resident had their own bedroom and access to appropriate bathroom facilities to meet their needs.

The centre had the use of one vehicle to use in the evening and at weekends to access the local community.

Staffing in this centre was allocated to support a semi-independent living model. One house had minimum staff support for a few hours each evening and the other house had staff support in the morning and evenings and had a sleepover staff at night.

Overall judgment of our findings:

The inspector found that residents were supported to make decisions and choices about their lives and were involved in the running of their house. All residents participated in social activities of their choice and some residents attended day care programmes in the nearby RehabCare resource centre. Residents' healthcare needs were met with support from their local general practitioners (GP) and access to allied health professionals was available as required.

However, the inspector found non-compliances in seven of the 12 outcomes inspected. Major non-compliance was identified in three outcomes and four moderate non-compliances were identified. The inspector found these non-compliances related to the provider and the person in charge failing to effectively review and implement organisational and operational policies and procedures in the centre.

In addition, the person in charge did not demonstrate an active presence in the centre to manage risks and to ensure that residents' support needs were being adequately met. For example, the inspector found some residents did not have daily activity programmes to suit their needs, social goals were not being met, complaints procedures and financial management audits were not in place and the provider failed to ensure robust oversight of risks and the quality of services provided in the centre.

Areas of non-compliance identified during the inspection are discussed further in the report and included in the action plan at the end of this report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

The inspector reviewed residents' rights, dignity and consultation in the centre and found that residents were supported to make decisions regarding their personal life and the daily routine in the houses. Residents' privacy and dignity were also respected and visitors were welcome to the centre. However, improvements were required in the management of complaints, such as recording and auditing of complaints and residents access to the complaints and appeals officer in the centre.

The inspector reviewed the two actions from the last inspection, which related to the management of complaints. The inspector found these actions were not complete. While the provider had a system in place to record complaints, the inspector found that all complaints were not recorded on the complaints log. The inspector was told that staff had addressed complaints and therefore, they had not recorded the complaints or the actions taken, the outcome of the complaint and whether it was to the satisfaction of the complainant.

In addition, there had been no audit or oversight of complaints management by the provider to ensure that all complaints were managed appropriately in the centre. Furthermore, the inspector found that although residents discussed complaints procedures at their residents' meetings, there was an absence of contact details available for residents to the complaint or appeals officer.

The inspector reviewed the financial recording system in operation to manage residents' money and found there was a good record of all transactions maintained in the centre;

however, the inspector found there was no evidence of financial audits completed.

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):

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

Findings:

The inspector reviewed the action from the last inspection, where not all residents had service-level agreements in place. On this inspection, the inspector found all residents had agreements in place, which outlined the terms and conditions of the service provided and the costs incurred by the residents.

Judgment:

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):

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

Findings:

Residents told the inspector that they enjoyed living in this centre and had a variety of

social opportunities available to them in the local community. The inspector reviewed the annual assessments of residents' health and social care needs and found that residents' healthcare needs were assessed and documented however, residents' social plans required updating to identify actions and timelines to achieve their goals.

The inspector reviewed a sample of residents' personal plans and found that each resident had annual reviews completed however, some personal plans had not been progressed or achieved over the past year and some residents' goals had been carried forward into their 2018 personal plan.

The inspector also found that the person in charge had not ensured adequate auditing and oversight of the residents' personal plans to ensure residents' goals were being met; for example, in August 2017 a resident had identified that they did not want to attend the resource centre as the activities on offer did not meet their interest and the resident had since stopped attending work.

This resulted in the resident remaining at home alone all week during the day without meaningful daily activities. There was no effective plan in place to assess the employment opportunities available to the resident or their social care needs and the resident's safety while being unsupervised alone at home during the day.

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 reviewed the health and safety and risk management procedures in place, including fire safety management and found that improvements were required in these areas. The inspector found that risk management procedures in relation to accidents were not robust and put residents at risk and required improvement and fire safety training was not up to date for some staff.

The inspector found fire safety measures were in place in this centre. Staff completed regular fire safety checks in relation to fire safety equipment and fire evacuation drills and residents and staff were able to tell the inspector how they would evacuate from the centre in the event of a fire. The inspector saw evidence of completed fire drills and the times taken to evacuate the two houses. However, not all staff had up-to-date fire

safety training and residents' personal evacuation plans required updating.

The inspector reviewed the management of risk in this centre and found that while the provider promoted residents' independence in the centre, they had failed to identify patterns of reoccurring risks and implement appropriate risk management procedures in the centre.

For example, the organisational risk register was not reflective of risks in the centre and there was no risk rating to identify the frequency or seriousness of the risks. In addition, staff had not received training in risk management and this was important as there were repeated accidents in the centre that had not been appropriately risk assessed or managed. For example, the inspector found two residents had received burns while cooking, (one resident on three occasions) and no appropriate safety measures had been put in place to prevent further repeated incidents occurring.

The inspector also reviewed the management of falls in the centre and found that two residents had fallen; one resident had two falls, which had required medical attention. However, there was no falls management policy or falls management plan in place for these residents, to identify their falls risks, or to assess their risks of further falls. In addition, not all staff had up-to-date safe moving and handling training.

There was one action from the last inspection relating to excessively hot radiators, this action was not complete. Although the person in charge told the inspector that in her opinion this risk was not a concern, the actions identified in the previous action plan response had not been completed to ensure residents were protected from a burn should they touch a hot radiator.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The inspector found that there were policies and procedures in place to protect

residents from being harmed or suffering abuse. Staff members were observed to treat residents with respect and warmth and residents told the inspector they were happy living in the centre. However, compatibility assessments had not been completed for residents living together, despite some evidence of conflict between residents.

There was a policy available on the prevention, detection and response to abuse and staff interviewed knew what constituted abuse and what to do in the event of an allegation, suspicion or disclosure of abuse, including to whom they should report any incidents to. The area manager was listed as the designated person and staff members were aware of her role. All staff had completed training in protecting vulnerable adults from abuse.

Staff said this service was a restraint-free environment and no physical or chemical restraints were used in the centre. However, there was an internal door to access between the two houses that was locked and only used for staff access, and the visitor's room in one of the houses was locked to secure residents' files. The rationale for these restrictions was not assessed and identified on a restrictive practices log in the centre.

The inspector found that, in general, residents got on well together in the centre however, the inspector was told that on occasions there would be conflict between residents; this usually happened in the independent house. This frequency of incidents had increased since an internal transfer had taken place between the two houses in 2017.

The frequency or extent of the conflict was not fully clear as the house had limited staff supports in place and this required review.

Furthermore, the inspector found that three staff did not have training in managing behaviours that challenge in the centre.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

Prior to this inspection, the inspector reviewed all notifications submitted to HIQA since the last inspection in 2015 and found that there were three six-monthly returns and

quarterly notifications submitted as nil returns. In addition, there were three, three-day notifications submitted to the Chief Inspector notifying HIQA of residents having accidents requiring immediate medical attention.

On this inspection, the inspector reviewed the number of accidents and incidents recorded in the centre's risk management system and found that four residents had six falls and two residents had four burns that had not been notified to the Chief Inspector as required.

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):

No actions were required from the previous inspection.

Findings:

Overall, residents' healthcare needs were met in line with their personal plans and assessments.

Each resident had their own general practitioner (GP) and an out-of-hours GP service was also available. Residents had access to a number of allied health professionals, including physiotherapists, occupational therapy and dietitians as required.

The inspector reviewed a sample of residents' healthcare files and found that their needs were appropriately assessed and were being met.

Each house in the centre had a fully equipped kitchen-come-dining area; this was observed to be an adequate space to accommodate the residents living in the centre. Records were maintained of daily menu plans which showed that a range of nutritious, appetising and varied foods were available in the centre and were chosen and cooked by the residents themselves. There was a food hygiene policy in the centre; however, not all staff had training in safe food and hygiene practices. This is actioned under workforce in outcome 17.

Judgment:

Compliant

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 appropriate written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

The inspector found that the procedures in place for the handling of medicines were in accordance with organisational policies. Most staff had up-to-date training in safe administration of medication however, the person in charge did not have up-to-date training.

The inspector also found there were several adverse incidents that had occurred in the centre and the actions taken following the medication errors were not clearly recorded in the post-incident reviews.

Judgment:

Substantially Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The centre's statement of purpose did not reflect the service and facilities provided and did not meet the requirements of Schedule 1 of the regulations.

Prior to the inspection, the inspector found that the provider had not submitted an up-to-date statement of purpose to HIQA to reflect the current service provision to ensure the requirements of Schedule 1 were adhered to.

The inspector requested an up-to-date statement of purpose to be submitted post inspection to reflect the requirements of schedule one of the regulations, however, on review of the revised statement of purpose, it did not meet the requirements and the provider was requested to resubmit the statement of purpose a second time.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found that the governance and management of this centre had failed to ensure a safe service for residents. The inspector found that there was an absence of a robust oversight by the provider and the person in charge and while residents told the inspector they were happy living in the centre, there was significant evidence found during the inspection to show that the provider was not meeting the requirements of the care and support regulations 2013.

The inspector reviewed the actions from the last inspection in December 2015 and found that six of the eight actions had not been completed. These actions related to complaints, social care needs, risk management, managing behaviours that challenge, statement of purpose, and records and documentation.

The inspector reviewed the provider's oversight of the centre since the last inspection and found that although the provider had completed the six-monthly unannounced inspections and the annual review of the centre, issues identified by the provider representative during these reviews had not been addressed and there was no follow up by the provider to ensure these actions were completed. In addition, significant risks had occurred in the centre and were not effectively managed or systems put in place to manage the risks.

The person in charge was in post since the last inspection in 2015 and was familiar with the residents living in this centre. She worked full-time and was responsible for running two day services in Lifford and surrounding areas, as well as being person in charge for

this centre.

The person in charge was rostered to work a couple of hours each week in the centre, however, the inspector found that this was not sufficient as there was an absence of effective management and oversight in this centre, for example, there was no schedule of audits covering issues of concern; such as, personal plans, risk management, complaints, assessments of support needs, and notifications, and staff training.

Inspectors found that the provider's risk management systems were not being implemented to effectively monitor risks, such as the risk of burns from the cooker and hot radiators.

The inspector further found that governance and management arrangement had not ensured that residents' support requirements were assessed to identify staff support needs, and staff had not received up-to-date training in-line with the provider's policies.

The provider had failed to assess the effectiveness of all systems in place at the centre.

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):

No actions were required from the previous inspection.

Findings:

The inspector found that the person in charge supported staff on a regular basis to have individual support and supervision meetings and team meetings. A new team leader had been appointed to the centre since January 2018 to manage the centre in the absence of the person in charge. However, there was an absence of a staffing needs assessment and staff training analysis to ensure the supports provided in the centre were effective in meeting the current needs of the residents.

This centre provided supported accommodation for six residents with an intellectual disability. One house received significantly more staff support than the other, however, the inspector found that an updated staffing needs analysis was required to ensure the individual support needs of each resident in the centre were being met, as their needs

change.

The inspector reviewed staff training records and found that these were not up to date. The inspector found staff had not received all of the training required to support residents living in this centre; for example, fire training, safe moving and handling training, managing behaviours of concern, mediation management, safe food hygiene, and risk management were not up to date for all staff working in the centre. In addition, some bespoke training was required such as the management of diabetes, as only one staff member had training in this area and all staff required training to ensure they could effectively support residents' healthcare needs, as required.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

The inspector found that the provider had not ensured that all records and documents required under the regulations were being maintained. The inspectors found that the provider had an up-to-date directory of residents which reflected changes in the occupancy at the centre. However, the Schedule 4 and Schedule 5 documents were not fully up to date.

The inspector reviewed policies and procedures available at the centre during the inspection. The inspectors found that the provider had not ensured that policies were up to date in accordance with Schedule 5 of the regulations.

The inspector further found that records required under Schedule 4 were not consistently kept up to date or included all required information under the regulations. For example, inspectors found that although complaints were recorded, documentation reviewed did not consistently show that investigations had taken place or show the

satisfaction of the complainant with an investigation's outcome. This non-compliance has been actioned under outcome one.

Judgment:
Substantially Compliant

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 report¹

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002678
Date of Inspection:	25 January 2018
Date of response:	16 February 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:

There was no evidence of financial audits completed in the centre, to ensure the financial support provided to residents to manage their money was maintained appropriately.

1. Action Required:

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

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

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

1. PIC will carry out a monthly audit on all money boxes, this will be documented on a monthly audit form.
2. Key Worker monthly review of residents plans to include a review of the supports required to manage their financial affairs and changes to their personal plan to be made as necessary.

Proposed Timescale: 09/02/2018

Theme: Individualised Supports and Care

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

1. The provider had not maintained a record of all complaints in the centre, or the actions taken to manage the complaints.
2. The outcomes of complaints were not recorded or whether the outcome of the complaint and investigation was to the satisfaction of the complainant.

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 will be managed in accordance with Rehab Group Complaints Policy and recorded on the organisations complaints management database.
2. Log of complaints has been devised for the purpose of capturing any expression of dissatisfaction by a resident, which will be addressed by the staff on that day.
3. Any expression of dissatisfaction that cannot be satisfactorily addressed will be managed through the Complaints Procedure.
4. Staff will record in their daily handover to PIC and rest of the team when they have addressed a dissatisfaction/complaint, in order to alert the PIC and team.
5. The PIC / PPIM will have weekly oversight of the log and will conduct an audit of the log on a monthly basis.
6. Learning from the management of complaints will be shared at each staff team meeting.
7. The residents will be supported to discuss The Complaints Procedure monthly at their house meetings.
8. A copy of The Complaints Procedure has been sent to the families of all residents who wish their family to receive a copy.

Proposed Timescale: 02/02/2018

Theme: Individualised Supports and Care

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

The nominated person to manage complaints did not ensure that all complaints are appropriately responded to and a record of all complaints maintained in the centre.

3. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

1. An easy read guide with a photograph and contact details for Integrated Services Manager who is responsible for appeals will be available in the centre. Residents will be offered the option of having the ISM's phone number stored in their own phones for easy access. This will be complete by Feb. 16th
2. The role of the ISM as an Appeals person for Complaints will be reminded at resident's house meetings. The next meeting will take place on Feb. 23rd.
3. The management of complaints will be reviewed at regular supervision meetings with PIC and ISM at least every quarter.
4. All complaints will be escalated in accordance with The Complaints Policy.

Proposed Timescale: 23/02/2018

Outcome 05: Social Care Needs

Theme: Effective Services

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

Arrangements had not been put in place to meet the assessed needs of each resident daily activities.

4. 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 MDT meeting will be scheduled for a resident currently not engaging in a day service to include her current day service provider, HSE, family and key worker. The purpose of this MDT will be to discuss resident's needs and formulate a plan to address same.

2. A range of options will be developed for the resident to sample within an agreed time frame and a further follow up MDT shall be convened at the end of the sampling period. Sample period to run from 27th Feb – 12th March (2 weeks).

3. This MDT shall agree with the resident which options will best suit the interests and aspirations of the resident and agree a commencement date and follow up review meeting. This will be complete by March 16th.

4. The Personal Plan will be updated to reflect the new plan and to identify any additional supports required.

Proposed Timescale: 16/03/2018

Theme: Effective Services

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

All residents' personal goals were not achieved in the previous year and there was no review system in place to audit the effectiveness of the current plans.

5. 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. PIC to meet with each key worker in order to assess the effectiveness of each of the six residents current Personal Plans in relation to their overall goals, short and long term action plans.
2. PIC and keyworker to action any updates required to ensure that each person has a robust, aspirational Personal Plan that encompasses all the elements of their life and evidences new opportunities.
3. PIC to review current and planned action plans for residents at each key worker supervision.
4. PIC and PPIM to audit one randomly selected Personal Plan per month, which will mean each Plan is audited at random twice annually.
5. PIC will review the agenda of each person's annual review to assure that plans are adequately reviewed and new plans are developed to a high standard. The PIC or PPIM will attend every annual review.

Proposed Timescale: 30/03/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The registered provider had not put effective arrangements in place to risk assess or manage individual or organisational risks in the centre.

6. Action Required:

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

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

1. PIC and team will attend Risk Management Training. This will be complete by March 31st.
2. PIC will update the Local Risk Register. To be completed by March 16th.
3. The PIC will review all the incident reports for the last 24 months and carry out a full assessment of the risk relating to each adverse incident in conjunction with the staff team and the residents. To be completed by March 16th.
4. PIC to share the learning from the review of risk assessments with the team. This will be complete by March 16th.
5. PIC to continue to participate in incident review meetings with National Health and Safety Team and Integrated Services Manager twice annually, or more urgently in case of any high risk incidents.
6. PIC to schedule an interim review with the National Health and Safety Team and Integrated Services Manager. This will be complete by Feb 28th.

Proposed Timescale: 31/03/2018

Theme: Effective Services

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

Although residents had personal evacuation plans in place, they required updating to clearly specify residents individual support needs.

7. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

1. PIC will review the PEEPs to ensure specific needs are detailed. Bedroom location to be added to each plan. – Completed. 09.02.17

Proposed Timescale: 09/02/2018

Theme: Effective Services

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

The provider had not ensured that all staff working in this centre had up to date fire safety training.

8. Action Required:

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

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

1. Fire safety training is scheduled for the staff and residents on Fri Feb 23rd

Proposed Timescale: 23/02/2018

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:

The person in charge did not complete compatibility assessments on residents prior to a recent internal transfer and had not put additional supports in place to minimize conflict in the centre.

9. Action Required:

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

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

1. PIC to risk assess the current living arrangements in relation to the potential for conflict and to put risk management measures in place to minimise the potential conflict. To be completed by 19/02/2018
2. PIC to carry out a compatibility assessment on the residents. 30/03/2018.
3. Following the compatibility assessment recommendations will be adopted and put into practice in the service. PIC will source any additional MDT support required

Proposed Timescale: 15/04/2018

Theme: Safe Services

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

Three of the four staff working in this centre did not have training in conflict or managing behaviours that challenge

10. 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:

- All staff to receive training in management of behaviour that is challenging including de-escalation and intervention techniques on 9th April.

Proposed Timescale: 09/04/2018

Theme: Safe Services

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

The use of locked doors in the centre were not risk assessed and recorded on the restrictive practice log.

11. 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:

1. As of Friday February 16th the practice of locking doors in the service will be discontinued.
2. PIC will ensure any future restrictive practices will be managed in accordance with organisational policy.

Proposed Timescale: 16/02/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

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

The provider had submitted 6 monthly nil returns on a number of occasions to the chief inspector, however, accidents and incidents that had occurred were not notified as required.

12. Action Required:

Under Regulation 31 (4) you are required to: Where no incidents which require to be notified have taken place, notify the chief inspector of this fact on a six- monthly basis.

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

1. With immediate effect the PIC or nominee will where no incidents which require to be notified have taken place, notify the chief inspector of this fact on a six- monthly basis

2. The PIC and PPIM to receive additional training in the regulations to include the notification obligations. To be complete on 7th March

Proposed Timescale: 07/03/2018

Theme: Safe Services

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

The chief inspector was not notified of all occurrences of serious injury to a resident which required immediate medical attention or hospital treatment.

13. Action Required:

Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

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

1. The PIC and PPIM to receive additional training in the regulations to include the notification obligations. Will be completed on March 7th

2. With immediate effect the PIC or her nominee will give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Proposed Timescale: 07/03/2018

Theme: Safe Services

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

The last two quarterly reports submitted to the chief inspector declared nil accidents and incidents in the centre, however, this notification was not accurate and accidents that had occurred in the centre, such as falls and burns were not reported as required.

14. Action Required:

Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

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

1. With immediate effect the PIC or her nominee will provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

2. The PIC and PPIM to receive additional training in the regulations to include the notification obligations. To be completed on March 7th.

Proposed Timescale: 07/03/2018

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:

The provider failed to implement an appropriate post incident review of medication errors in the centre and the person in charge responsible for reviewing medication errors did not have up to date training in safe medication practices.

15. 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. PIC has updated the training record to reflect PIC's recent medication training received on 06.10.17 and subsequent assessment on 12.10.17 - Complete
2. With immediate effect the PIC will carry out a post incident review on all medication errors in the centre and ensure that all learning from the incident is shared with the team at staff meetings.
3. The PIC will review the current Medication Policy in place within the Centre with all staff in their supervision to ensure that the systems are understood and followed and any gaps in knowledge are addressed. To be complete by Friday March 9th.
4. The PIC and PPIM will carry out a monthly audit on Medication Practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines in the centre.

Proposed Timescale: 09/03/2018

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not reflect the requirements of schedule one of the regulations.

16. Action Required:

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

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

1. The PIC has amended the Statement of Purpose and Function to reflect Schedule 1 requirements and submitted this to the Inspector.
2. The PIC will update the Statement of Purpose at least annually and send the updated version to the HIQA inspector

Proposed Timescale: 02/02/2018

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:

The governance and management systems in this centre, did not ensure the delivery of a safe, and good quality services to residents.

17. 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. Team meetings to occur every 4 weeks.
2. PIC and PPIM to meet weekly, to ensure there is adequate oversight of activities, and any ongoing actions within the service.
3. Formal supervision will happen for all staff members including PIC and PPIM,
4. PIC and ISM will meet on a six weekly basis to review progress actions arising out of any audits completed within the service.
5. The PIC and PPIM will continue to carry out a monthly hazard inspection of the service. Each month's actions arising from the previous month will be followed up.
6. There will continue to be unannounced visits twice annually to the centre.
7. The Provider Representative Nominee will oversee the development and ongoing implementation of a Service Improvement Plan including the recommendations arising this inspection.
8. The Integrated Services Manager will carry out an annual review.
9. PIC and PPIM will carry out review of service user plans and progress and medication practices at regular intervals.

Proposed Timescale: 28/02/2018

Theme: Leadership, Governance and Management

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

The inspector found that actions from the provider's unannounced six monthly visits were not addressed within agreed timeframes. In addition, the provider did not have an effective plan in place to ensure that the organisational policies and procedures were being implemented in this service.

18. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

1. Following six monthly unannounced visits the PIC will follow up and ensure identified actions are addressed in a timely manner. The most recent action plan will be reviewed by the PIC by 23rd February.
2. Review of actions identified through six monthly unannounced visits will form part of the agenda for progress meetings between the PIC and Integrated Services Manager.

Proposed Timescale: 23/02/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

The provider did not ensure that there was an up to-date staffing needs analysis completed to identify residents individual needs in the centre.

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:

- Following review of service user plans, risk assessments and compatibility assessment, the PIC in conjunction with the Integrated Service Manager will review staffing levels and identify any additional staff training needs to assure the skill mix and skills of staff is appropriate to the assessed needs of residents.

Proposed Timescale: 30/03/2018

Theme: Responsive Workforce

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

All staff did not have up to-date training in fire and risk management, medication management, safe moving and handling, managing behaviors that challenge and food safety management.

20. 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:

All staff will have completed the following training:

- Fire Safety Training – 23.02.2018
- Risk Management 16.03.18
- Safe Administration of Medication Assessment – completed.
- Safe Moving and Handling – 09.04.2018
- Managing Behaviours that Challenge 17.04.2018
- Food Safety Management 13.04.2018
- Briefing on Regulations 07.03.2018

Thereafter the PIC will ensure all staff receive training including refresher training within required timeframes

Proposed Timescale: 17/04/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

The inspectors found that the provider had not ensured that policies were up-to-date in accordance with Schedule 5 of the regulations.

21. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

- All organisational policies as per schedule 5 of the regulations have been reviewed by subject matter experts in the last 12 months. The majority of these policies have been circulated and are available to guide staff practice. The remaining policies will be signed off and circulated to services by March 31st.

Proposed Timescale: 31/03/2018