**Health Information and Quality Authority**

**Regulation Directorate**

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Cherry Orchard Hospital</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003730</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Dublin 10</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>Karina O'Sullivan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Thomas Hogan</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>28</td>
</tr>
<tr>
<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 inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 09 November 2017 08:30
To: 09 November 2017 19:15

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

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Summary of findings from this inspection
Background to the inspection:
An initial inspection of this centre was completed 2015, with a subsequent inspection in 2016. This was a result of the provider submitting an application to register this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, at the time the centre was not found to be in sufficient compliance with the regulations in order for the Chief Inspector to grant registration. This was the third inspection of this centre, and it was conducted to inform a registration decision. The provider has applied to register this designated centre for 34 residents, however, during the inspection the person in charge identified this had reduced to 32 residents.

How we gathered our evidence:
As part of the inspection, inspectors visited the designated centre, met with approximately 24 residents and spoke with the provider, person in charge and seven staff members. Inspectors viewed documentation such as; care plans, person-centred support plans, recording logs, policies and procedures. Over the course of this inspection, residents communicated in their own preferred manner with inspectors. Residents allowed inspectors to observe their daily life in the centre, this included meal times. Inspectors spoke with six residents. Some residents allowed inspectors to view their bedrooms.

Description of the service:
This designated centre is operated by the Health Service Executive (HSE) and is based in Dublin. The designated centre is located within a hospital campus and consisted of two separate buildings in close proximity to each other. The provider had produced a document called the statement of purpose, as required by regulation. This described the service provided. Inspectors found the service provided was not in line with the statement of purpose. On the day of inspection there were 28 residents in the centre. One unit had the capacity to accommodate 12 residents and the second unit had the capacity to accommodate 21 residents. On 28 residents were present within the centre between the two units. As detailed in their statement of purpose the designated centre aimed to provide continuing care to young chronic sick individuals, including six respite beds to both male and female residents over the age of 18.

Overall judgments of our findings:
Inspectors found that significant progress was not evident in order to bring about compliance with the regulations and improve the quality of life residents' experienced while living in this centre. This was compounded by a lack of oversight and a lack of clarity and accountability regarding roles and responsibilities. For example, residents social care needs were poorly met within the centre and appropriate measures to ensure residents were safeguarded were not in place. In addition, inspectors found that residents' rights were not always upheld due to the practices in place within the centre.
This inspection report identified 47 actions in need of address 12 of which were also identified on the previous inspection. This resulted in ten outcomes being evidenced as majorly non-compliant:

Outcome 1: Residents rights, Dignity and consultation
Outcome 4: Admissions and Contracts for the provision of services
Outcome 5: Social Care Needs
Outcome 6: Safe and suitable premises
Outcome 7: Health and safety and Risk management
Outcome 8: Safeguarding
Outcome 9: Notifications
Outcome 10: General welfare and development
Outcome 14: Governance and Management
Outcome 18: Records and documentation

The remaining five outcomes inspected against, were found to be in moderate non-
compliance.

The person in charge facilitated the inspection together with a clinical nurse manager.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.
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:
Residents’ privacy, dignity and respect was not always upheld by practices within the centre. Inspectors observed evidence of institutional type practices in operation within the homes of residents.

Inspectors found the privacy and dignity of residents in relation to their living space was compromised. Staff members from various locations, on campus were observed entering the homes of residents without knocking or ringing the door bell. On arrival to the centre staff failed to query as to who the inspectors were nor did any staff seek identification from them. Inspectors heard staff members speak among themselves in a language not familiar to residents. Inspectors also observed that some residents had inadequate space to store and maintain their clothes and personal property and possessions.

Inspectors found significant improvements were required in relation to residents’ finances. Inspectors were not assured that residents were consulted with regarding their finance. Some residents within the centre had restricted access to their finances, as this was managed through the campus manager’s office. Some residents could only access their money at specific times when the office was opened, Monday to Thursday from 10:00hrs to 12:30hrs and 14:15hrs to 16:00hrs. Inspectors enquired as to the absence of expenditure from some residents’ accounts and were informed that residents without capacity to manage their financial affairs would generally not need to spend money as they would not be going on day outings from the designated centre.
Inspectors observed routines which were task orientated and practices which did not promote residents' independence or choice. Consultation with residents was also limited which subsequently impacted on their freedom to exercise choice and control over their daily life, institutional type practices were in place within the centre. For example, inspectors observed some residents to be asleep in bed, yet, their bedroom doors were open and other staff members and residents were walking up and down the corridor. In addition some residents identified they did not know what they would receive for dinner until it came out of the kitchen. Inspectors also observed that residents waited for a trolley to come around at a standard time such as, 11:00 hours, for snacks as oppose to accessing food at a time of their preference.

Inspectors also found some residents did not participate in decisions about their care, this was illustrated through minutes of a multi disciplinary meeting viewed. Inspectors found the approach lacked consultation with the resident, family members and advocate as none of these people were present at the meeting.

Inspectors viewed the complaints log within the centre. Improvements were required in relation to the implementation of the complaints procedure and the follow up of some complaints. Some complaints remained unresolved. Outcomes or follow ups in some instances were not documented.

**Judgment:**
Non Compliant - Major

### Outcome 03: Family and personal relationships and links with the community
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
Residents links with the wider community in accordance with their wishes were very limited.

In one unit 17 social activities recorded since 25 July 2017. Seven of these were to the local church to attend mass. The other ten consisted of trips to a shopping centre. One resident attended all trips, therefore, all residents were not afforded equal opportunities.

Inspectors were informed one resident was attending college, however, staff spoken with were not aware of what course this was.

Inspectors found visits were restricted. The visitor’s policy stated that residents could
receive visits between the hours of 08:00hrs to 20:00hrs. If residents were to receive visits outside of these hours permission must be granted by the management team. Inspectors found this policy lacked consultation with the residents themselves and was restrictive.

**Judgment:**
Non Compliant - Moderate

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**Outcome 04: Admissions and Contract for the Provision of Services**
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

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

**Findings:**
Inspectors viewed a sample of five written contracts of care and these remained unclear in relation to what services were provided to each resident.

**Judgment:**
Non Compliant - Moderate

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**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 did not have the opportunity to participate in meaningful activities that were appropriate to their interests and preferences. In addition, staff members were not guided effectively as some residents did not have up-to-date personal plans in place.

Inspectors requested to view eight specific residents' personal social care plans, three residents had a plan in place, out of the eight requested. From the plans viewed these were not social care plans, as medical conditions were outlined as being goals such as, maintaining body temperature.

Goal planning at the centre was inadequate. Two plans focused on increased activities as a goal, the action plan stated that staff members spoke with the resident’s family and the family members agreed they would try and increase activities when the resident visited them at home during the weekends. Therefore, the social care needs of residents were redirected to family members to achieve instead of the staff members within the centre. Inspectors found there was an overall lack of evidence, that staff members had an awareness of social care and what was outlined within the regulations in relation to social care provisions.

Inspectors were informed of a future social activity in relation to a shopping trip for residents. On the day of inspection four residents had put their names on the list up on the wall. Inspectors observed if residents could not reach the list on the wall or read the notice they may not be afforded the opportunity to partake with this activity.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
Significant improvements were required in relation to the layout of this centre.

The centre comprised of two units, one unit had a bed capacity of 12 beds and the second unit had a bed capacity of 21. Two bedrooms within the centre were single rooms and the rest of the bedrooms were either double, triple or quadruple bedrooms.
Therefore, this limited the amount of privacy and dignity available to residents. However, inspectors acknowledged bed screens were in place, while intimate care was being completed.

The centre was unclean in areas and poorly maintained, inspectors viewed dried in food particles and fluid stains within the dining room. One inspector lifted up the table cloths within one of the dining rooms and this was difficult to move as it was stuck to the table with a build up of moisture and food debris. Walls within the hallways were in need of repair, as paint was chipped and falling off walls.

The outside of one unit required upkeep as litter was evident in the form of several paper wrappings and tissues along with layers of dead leaves. Inspectors found this area was not inviting for residents to spend time outside in the seated area nor was it safe for residents due to the surface being unkempt.

Inspectors found some of the requirements of Schedule 6 were not provided in relation to privacy and dignity.

In response to the previous inspection in relation to the premises, the provider identified a new build would be completed by 2021, for the older persons. This in turn would facilitate the relocation of one of the disability units to the previous older persons centre.

The layout of the units and the lack of adequate private and social accommodation did not lend itself to a homely atmosphere.

**Judgment:**
Non Compliant - Major

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**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):**
No actions were required from the previous inspection.

**Findings:**
The health and safety of residents, visitors and staff was not promoted and protected within the centre.

There were various policies in place in relation to health and safety and risk management, however, none of these were up-to-date. For example, the risk management strategy policy was dated 18 June 2014 and the quality and risk management handbook was dated 2007.
Inspectors found significant improvements in relation to fire management was required. Staff members were not guided adequately in relation to fire management to ensure all residents could effectively be evacuated. Some members of staff they were unable to identify where the fire exits were located and were also unable to outline the procedure in the event of a fire during the night. Staff members spoken with were unsure of how many people were required to evacuate the unit. Some staff members suggested ten staff members would come and help out as an alarm would sound on campus to alert staff members to the fire. Inspectors requested to view the plan in place for this, however, this was not available. Inspectors requested to view residents' personal evacuation plans and inspectors were provided with a one page document which only identified residents' mobility status. This document failed to effectively guide staff in relation to safely evacuating residents. This was further compounded by the fact that the fire drills, which were taking place, did not involve participation from residents. Instead staff members simulated drills within the centre.

Inspectors found there were inconsistencies in the servicing of some fire fighting equipment. A fire blanket had not been serviced since April 2012 and another one was serviced since April 2016. Inspectors identified the system of annual servicing of fire fighting equipment required review.

Inspectors viewed 42 incidents and found that the follow up to a number of the incidents was unclear and learning had not been identified from the incidents ensuring risk was mitigated. The risk assessments in place, required review as some of these did not have any rating identified in relation to the actual risk. Additional areas requiring attention also included containers for sharps which were untagged and did not have any identification in place. The build up of dead leaves within the outside seating area was also not identified as a potential risks for all people within the centre.

Emergency lighting was in place and records were available to identify this was serviced annually.

**Judgment:**
Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**
Safe Services

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

**Findings:**
Measures to safeguard residents were not in place within the designated centre. Inspectors found incidents, allegations and suspicions of abuse at the centre were not appropriately investigated in accordance with policy, national guidance and legislation.

From viewing the training records some staff members had attend training in the area of safeguarding residents and the prevention, detection and response to abuse. However, inspectors spoke with six members of staff, however, none of whom could demonstrate sufficient knowledge in this area. No staff member spoken with could outline the different forms of potential abuse or the reporting structure within the centre. In some instances, inspectors were informed staff members would use the complaints process for allegations of abuse. Another staff member identified they would use the internet to source guidance in this area. Other members of staff identified they would speak with the alleged abuser to ensure the information was accurate and inform them of the allegation, before escalating this to members of management. Some residents stated they felt unsafe in the centre and identified there was no point in raising issues as nothing would be done.

Inspectors were not assured that appropriate actions were taken in response to allegations, disclosures or suspected abuse. From viewing records within the centre, inspectors found some potential allegations were not identified. Inspectors highlighted a sample, to the person in charge during inspection.

The person in charge identified that seven long standing members of staff were, yet, to be Garda vetted. However, this would be completed within the required time of the national vetting bureau (children and vulnerable persons) act 2012. Inspectors requested evidence that agency staff were Garda vetted. The person in charge identified that five agency organisations were used within the centre. Inspectors were provided with conformation that two agency organisations had arrangements in place for their staff members to be Garda vetted prior to completing any shifts. No evidence was available for the other three agencies used.

Inspectors requested to view documents and plans in place in relation to intimate care. This was requested and rephrased five times, however, inspectors were not provided with this information from front line staff members.

Inspectors found inappropriate arrangements in place ensuring residents' finances were safeguarded. There was also conflicting views on who was responsible for the oversight of residents' finances. The person in charge identified this was not the responsibility of staff within the units, however, the campus manager identified it was the staff members within units who were responsible to maintain accurate records and submit these to the financial office. Inspectors were informed that the organisation was assured that residents' money was safeguarded. However, on viewing a sample of three residents accounts the following was identified, in one incidence €41.30 was unaccounted for and in another file €127.50 was unaccounted for and within the third file a sum of €30 was unaccounted for. Inspectors requested to view the last two financial audits conducted.
within the centre, however, staff members were unable to locate these on the day of inspection. Inspectors requested for these documents to be submitted post inspection, at the time of writing this report no audits were received.

Inspectors also requested information in relation to the type and management of resident’s financial accounts. This information was not available on the day of inspection, this was submitted post inspection. Overall, inspectors, were not assured in relation to the systems in place to manage residents’ finances within the centre.

**Judgment:**
Non Compliant - Major

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<th>Outcome 09: Notification of Incidents</th>
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<tr>
<td><em>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</em></td>
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**Theme:**
Safe Services

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

**Findings:**
During the inspection, inspectors identified incidents which were required to be notified to the Chief Inspector. These included an unexpected death of a resident and allegations of abuse. Following inspection these were submitted retrospectively.

**Judgment:**
Non Compliant - Major

<table>
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<th>Outcome 10. General Welfare and Development</th>
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<tr>
<td><em>Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.</em></td>
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**Theme:**
Health and Development

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

**Findings:**
Opportunities for residents to participate in new experiences, social participation, education, training and employment were very limited. This was also identified during the previous two inspections.

Inspectors were informed assessments were completed with relevant and appropriate links established based on residents' needs and preferences. Inspectors requested to view these assessments; however, some of these were either not completed or awaiting a clinical nurse managers approval.

From speaking with some residents, this aspect of care delivery required significant improvement.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Health and Development

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

**Findings:**
Inspectors found some residents' healthcare needs were met, however, improvements were required in relation to healthcare plans.

From the sample of ten residents' healthcare files viewed, inspectors found overall some residents’ healthcare needs were met; however, there were significant deficiencies within the maintenance of the documents.

Inspectors requested to view two plans of care in place for specific healthcare conditions, however, these were not available. Therefore, staff members were not guided effectively and consistently in relation to the management of all healthcare conditions.

Inspectors observed one resident inform a member of staff that they had an ailment, yet, two and half hours later this was not responded to. On viewing the resident’s medication chart no pain relief was offered nor was there evidence that any other therapeutic intervention was provided to this resident to elevate their symptoms.

Inspectors acknowledged the improvements with the use of stools for staff members to use when assisting residents with their meals. Inspectors observed residents being feed
in a respectful manner by staff sitting with residents and maintaining eye contact and communicating with residents during their meals.

Access to snacks outside of meal times were exceptionally limited, inspectors within one unit request to view the food supplies and found limited choice in relation to food available for residents.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
Medication management within the centre required improvement to ensure suitable practices relating to the storing, disposal and administration of medication.

The designated centre had written policies and procedures which related to the administration, transcribing, storage, disposal and transfer of medicines. However, the inspector found this policy was dated 10 December 2009.

On viewing 17 residents’ medication administration charts, no guidance was available in relation to the administration of some PRN medicine (a medicine only taken as the need arises). Inspectors found staff members were not always guided effectively and consistently in the administration of these medication.

Inspectors also found one administration chart did not contain a photograph of the resident. Overall, inspectors found the writing within the charts was illegible.

Capacity assessments had not been completed for residents in terms of their ability or wish to potentially take responsibility for their own medication.

There was a system in place for recording, reporting errors and reviewing medication. However, this was not wholly effective as inspectors found medication remained in the centre for a resident who had passed away. On the day of inspection no medication errors had been recorded at the centre.

Inspectors found the signature bank within the designated centre was completed.
Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found the statement of purpose did not fully meet the requirement of schedule 1 of the regulations. This was also identified on the previous two inspections.

The document identified areas within the campus not relevant to this designated centre.

Inspectors were provided with an updated copy of the document, version six from the provider in June 2017. On the day of inspection, inspectors requested a copy of the current document within one of the units and were provided with version three of the document which was an outdated version. Therefore, copies of the current statement of purpose was not available to residents and their representatives from a unit perspective if requested.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Significant improvements were required with regards to the oversight of the centre to ensure the safe, consistent and effective delivery of care in accordance with residents’ needs. This was evident through the findings of this inspection and the level of non-compliances identified and how these were impacting negatively on the quality of lives for residents living in the centre.

Inspectors found the management structure did not have clear lines of authority, and accountability. Roles and responsibilities were also not clearly defined. The management structure of the designated centre failed to ensure the provision of a qualitative and safe service to residents in a consistent manner.

The provider had previously identified the dual responsibilities the person in charge had for this centre and for an older persons service was not effective. Furthermore it was identified this would be changed by the end of December 2017. During this inspection no changes had occurred.

Inspectors found the monitoring of the service provided was not effective as limited audits were conducted. In some incidences when inspectors requested to view audits they were provided with campus based audits instead of centre based audits and in one incidence were provided with an audit from the older persons centre. The required audit was subsequently submitted to inspectors post inspection.

Effective arrangements to support, develop and performance manage all members of the workforce was not occurring within the centre. The centre had no system in place in relation to performance appraisal for all staff members. Inspectors identified this did not facilitate staff members to exercise their personal and professional responsibility for the quality and safety of service they provided within the centre.

The provider had carried out an unannounced visit on a six monthly-basis in 2016 in this centre.

Accurate copies of the report of the unannounced visit to the designated centre were not available on request to residents and their representatives and to the representatives of the chief inspector during this inspection. From the copies viewed during the inspection, inspectors were unclear in relation to when one actual visit was completed as information within the document contradicted the date it was completed. Inspectors viewed a second visit available within one unit, however, following inspection, inspectors received an email from the provider, this identified the second visit viewed during inspection was incorrect version of their visit was provided during the inspection.

Inspectors acknowledged that an annual review was completed since the previous inspection.
Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Improvements were required in relation to the information contained within the staff rota and the provision of refresher training.

Inspectors viewed the staff rota in one unit and identified it was not reflective of practice. For instance, inspectors were informed that two staff nurses and one healthcare assistant were required to be present each night. On viewing the previous rota for the last eight nights, one nurse was present on the rota for three of these nights. Inspectors were informed the staff member should have written their names onto the rota when they arrived. Inspectors asked who the second nurse was on the night of inspection and were informed they would know when the staff arrived. During the evening time, inspectors overheard two residents ask staff members who were the staff on duty that night, however, staff members were not able to fully answer this question. In addition inspectors identified the times night staff worked was not documented on the rota. The clinical nurse manager identified that a second nurse was always on duty. The person in charge also confirmed this during feedback and identified the names of the staff would be available in the rostering department.

During the inspection, inspectors became aware that at night one member of staff had to assist in another unit on campus, however, this was not reflected on the rota. Therefore, residents did not know who was coming on shifts some nights. In addition inspectors were informed that a clinical nurse manager identified on the rota as off was conducting interviews for staff vacancies on the day of inspection.

From viewing 36 members of staff training records, the following percentage of staff required refresher training in the areas identified: 16% in fire, 49% in the management of behaviour that is challenging including de-escalation and intervention techniques and 17% in relation to safeguarding residents and the prevention, detection and response to abuse.
From discussions with staff members inspectors formed a view staff members were not knowledgeable in relation the Act and the regulations and standards from a disabilities perspective.

Staff files for the designated centre were not viewed during this inspection, these are located off site.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Significant improvement was required in relation to the maintenance and development of the required documents as identified within the regulations.

Inspectors views the schedule 5 policies, the person in charge identified the centre did not have a policy in relation to access to education, training and development.

Several other required policies were not reviewed at intervals not exceeding 3 years such as, the medication management policy was dated 10 December 2009, incidents where a resident goes missing was dated 03 March 2010, provision of behavioural support was dated 2010, visitors policy was dated 18 October 2013, provision of information to residents was dated 20 September 2009, communication with residents was dated 02 February 2009, complaints policy was dated 2009, risk management was dated 2007 and the creation of, access to, retention of, maintenance of and destruction of records was dated 2011.

Inspectors also found some policies were not available in the designated centre these included the staff training and development policy and the recruitment, selection and
Garda vetting policy.

The directory of residents was viewed during the inspection and the required improvements to ensure the information specified in Schedule 3 were not included such as, the name of resident's general practitioner.

**Judgment:**
Non Compliant - Major

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**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:**

Karina O'Sullivan
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-0003730
Date of Inspection: 09 November 2017
Date of response: 30 January 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 Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Each resident, in accordance with their wishes, age and the nature of their disability, did not participate in and consent, to decisions about their care and support as illustrated in the minutes of the multi disciplinary meeting.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support.

Please state the actions you have taken or are planning to take:
1. Each resident will be given the opportunity to attend a MDT meeting if they wish effective from 01/02/18. This will be reflected in the notes of the meeting.
2. New updated and revised consent policy (2017) has been disseminated to units.
3. Two person-centred planning workshops are planned for January 2018 facilitated by staff from the Muiriosa Foundation. It is planned for Muiriosa to facilitate a person-centred planning session with a resident and members of the multidisciplinary team during February 2018 to further guide and support staff in implementing appropriate individualised social care plans for residents.
4. All person-centred plans will be reviewed over the next 4 months. How residents will be encouraged to be involved in the development of their Personal Plans will be added to the agenda of resident meetings.
5. Promotion of greater advocacy to support residents is currently being explored with members of the wider multidisciplinary team to support residents. Currently social work provide one to one advocacy to the centre. An enhanced model of advocacy support will be developed by 14/02/18.
6. Confidential Recipient details are now available in the designated centre and displayed for residents to access.
7. Key worker role is being enhanced to support all residents on an on-going basis regarding decisions about their care and support.

Proposed Timescale: 28/02/2018

Theme: Individualised Supports and Care

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

Each resident's privacy and dignity was not respected in relation to, but not limited to, their personal and living space and intimate and personal care.

Residents were required to share bedrooms.

Some residents were asleep with their bedroom doors open while other members of staff and residents were walking up and down the corridor.

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:
1. Signage has been placed at the front entrance to the centre directing staff to ring the
doorbell prior to entering the units.

2. Staff have been advised of the importance of requesting identification from all visitors to the centre.

3. Staff have been advised to request all visitors to the centre to check in at reception, sign the log book and remain there until resident is available to see them. New visitors policy has been drawn up which incorporates points 1, 2 and 3, which is less restrictive and allows for open visiting, while respecting and safeguarding residents.

4. Staff will continue to be instructed by management to speak in English only on the unit.

5. Staff will ensure all privacy curtains are properly closed when delivering care.

6. An accessible visual survey with residents on what it’s like to live in the designated centre and what changes residents would like to see made to improve their lived experience has commenced. Full participation is being encouraged by staff. Key workers are conducting this on an individual basis with each resident as required. There are a number of residents who will not be able to participate in the survey due to the nature of their illness. Their families or representative have been asked to complete it on their behalf. Access to storage space for personal possessions has been included in this survey which will be completed by 07/02/18.

7. An environmental analysis which will seek to maximise utilisation of shared spaces has commenced which will be completed by end of February 2018. This will assist with increasing living spaces available to residents.

8. Model of monthly resident meetings will change. Residents will be consulted on how they would like to see this happen as part of the survey planned (see 6 above). All residents will see a copy of the minutes and follow up items will be addressed. A residents communication board will be put in place in the day room and dining areas with information accessible to residents. This will be done by 31/01/18.

9. Multidisciplinary meetings will be organised to include residents, family members and advocate if resident wishes this.

10. Residents have been consulted on whether they wish to have their bedroom door open or closed when they are asleep, notwithstanding the fact that the majority of the bedrooms are shared. This is documented in their care plan. This was completed by 31/12/17.

11. A copy of the menu will be made available to each resident individually on a weekly basis and will be displayed on the information board. This has been completed. Also, menu is displayed on the blackboard daily in the dining room. Ward catering staff speak to residents daily on an individual basis to ask them about their food choices for a particular day and to allow the resident to inform the staff if they are unhappy with the food choices available and to allow for alternative meal options to be organised in advance. Accessible food menus will be made available for residents who require this information in a different format. Residents will be consulted on food preferences at the monthly ward meetings and in the resident survey planned.

12. Snack fridge and snack area is being put in place in the dining area for residents. Options around this are currently being explored within the centre as part of the environmental space review. It is planned to have this snack area in place by 31/03/18.

13. It is planned to increase the General Administration hours for access to residents’ monies. The hours are restricted currently as there are two staff vacancies. The hours will be increased following the appointment of additional staff (April 2018). Monday to Friday opening will be implemented. A small safe for holding monies for out of hours access to money has been purchased and is now held at ward level. Where the resident
has capacity to manage their own financial affairs, the preferred option is that they continue to operate their own private bank account as they have greater access to their monies and to promote independence. Residents will be supported to open and manage private bank accounts for those who wish to. A new ‘Guidelines for Residents’ Monies’ procedure has been implemented. These guidelines provide comprehensive guidance on the procedures for accessing residents’ funds and ensuring that expenditure is documented and receipted particularly for residents who do not have capacity to manage their own financial affairs. The Patients’ Private Property Policy has also been amended to tie in with the new Guidelines.

14. New guideline on privacy and dignity has been completed which provides clearer guidance for staff and addresses points 4, 5 and 10. This is now operational and staff awareness of this new policy took place at this time.

15. There is an education session scheduled for staff on Trust in Care on 29/1/2018 organised by the NMPDU.

16. Resident communications – designated space to access computer and quiet telephone space will be implemented in the context of environmental analysis.

**Proposed Timescale:** 30/04/2018

**Theme:** Individualised Supports and Care

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

Residents had limited freedom to exercise choice and control over their daily life as the centre was routine based.

3. **Action Required:**

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

1. Resident views on the running of the centre are being ascertained via a survey which each resident will be supported to participate in. This information will be used to ensure that each resident has the freedom to exercise choice in their daily lives.

2. The model of monthly resident meetings is changing to ensure feedback from the accessible visual survey remains an agenda item until resolution.

3. Greater transport options are being sourced to provide opportunities for residents to access community more easily.

4. All residents will have access to their own personal funds at ward level

**Proposed Timescale:** 28/02/2018

**Theme:** Individualised Supports and Care

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

Some residents were not consulted in the organisation of the designated centre. This
was evident from speaking with residents in relation to meal times and the allocation of bedrooms.

4. **Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

**Please state the actions you have taken or are planning to take:**
1. An accessible visual survey on what it’s like to live in the designated centre and what changes residents would like to see made to improve their lived experience is underway. Key workers are conducting this on an individual basis with each resident where support is required. Where residents are not able to participate in the survey due to the nature of their illness their families or representative has been asked to complete it on their behalf. The independent advocate may also be used.
2. The model of resident monthly meetings will change from 28/02/18 and feedback from this survey will be included as one of the items addressed. Minutes will be available to all residents in an accessible format and action will reviewed monthly.
3. A residents communication board will be put in place in the day room and dining areas with information accessible to residents. This will be done by 31/01/18.
4. Residents are given the option to move rooms as they become available. This discussion will be documented in their file.

**Proposed Timescale:** 28/02/2018

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some residents could only access their money at specific times. The office was opened Monday to Thursday 10:00hrs to 12:30hrs and 14:15hrs to 16:00hrs.

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

**Please state the actions you have taken or are planning to take:**
1. A safe has been purchased for the designated centre to facilitate full access to money out of hours for residents. This will be done by 28/02/18.
2. Opening hours in the main cash office will be increased to facilitate Monday to Friday opening following the recruitment of additional staff with an anticipated date of 30/04/18.
3. A number of residents independently manage their own finances and use the individual locked storage press in their rooms. Staff will also continue to support residents to access money in financial institutions.
4. Guidelines for the Management of Residents Monies were drafted and implemented on the 18th December 2017.
5. Capacity assessment to be carried out for each resident and will be completed by
6. A Policy and Procedure for Management of Resident’s Property has been drafted to ensure that resident interests are protected.

**Proposed Timescale:** 30/04/2018  
**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Some residents had inadequate space to store and maintain their clothes and personal property and possessions.

6. **Action Required:**  
Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.

**Please state the actions you have taken or are planning to take:**  
1. Each resident is being consulted regarding their personal space by their key worker. All conversations to be documented in their personal files and appropriate actions taken as arise from these conversations. This topic will also be included as a question in the survey planned for residents.  
2. One resident has been provided additional space outside his bedroom and it is being encouraged to use this space for his other possessions. This is shown in the resident’s care plan.

**Proposed Timescale:** 14/02/2018  
**Theme:** Individualised Supports and Care

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**  
Some complaints remained unresolved without any outcomes documented for the complainant.

7. **Action Required:**  
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

**Please state the actions you have taken or are planning to take:**  
1. Audit of complaints against the policy will be carried out by the provider nominee on a quarterly basis, with the first audit taking place by 31/03/18.  
2. Outcome of complaints to be clearly documented and actioned immediately, with the complainant informed promptly about the outcome from 19/01/18.  
3. Complaints and the learning from them will be included as standing agenda item at monthly disability management meetings, Quality and Risk Committee, and disability
team unit meetings.

**Proposed Timescale:** 30/03/2018  
**Theme:** Individualised Supports and Care

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**  
Some complaints viewed did not identify what measures were put in place for improvement in response to the complaint.

8. **Action Required:**  
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

**Please state the actions you have taken or are planning to take:**  
1. Complaints to be clearly documented and actioned immediately to include required improvements. These will be discussed at monthly disability management meetings, quality and safety meetings, disability team unit meetings, and improvements reviewed.  
2. Audit of complaints will be carried out by the provider nominee on a quarterly basis, with the first audit taking place by 30/03/18.

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**Proposed Timescale:** 30/03/2018

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**Outcome 03: Family and personal relationships and links with the community**  
**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
The visitors policy restricted the visiting hours for residents and visits outside the times specified had to be granted by management consultation with the resident themselves was not provide for within the document.

9. **Action Required:**  
Under Regulation 11 (2) (b) you are required to: Ensure that as far as reasonably practicable, residents are free to receive visitors without restriction unless the resident has requested the restriction of visits.

**Please state the actions you have taken or are planning to take:**  
1. Visitors policy has been reviewed and updated specifically for disability units.  
2. Resident consultation will take place if there is a request for visiting times later at night.

**Proposed Timescale:** 19/01/2018
**Theme: Individualised Supports and Care**

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Residents had limited links to the wider community.

**10. Action Required:**
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

**Please state the actions you have taken or are planning to take:**
1. Review of Needs assessment previously done to be carried out with each resident by the multidisciplinary team. These will be completed by 28/02/18.
2. Additional community activity programmes every second weekend has commenced weekend of 09/12/17. This is in addition to activities programme already available in the designated centre.
3. Links with disability day services and rehabilitation services are being explored via rehabilitation and guidance service CHO 7 to support residents who wish in accessing community supports in this area.
4. Residents will be consulted at resident meetings and via the survey on what types of community links they would like to participate in.
5. Review of visitors policy will facilitate and support greater personal links for residents.
6. Private space in designated centre to access computer (from 28/02/18) will facilitate residents to develop and maintain their links with the community.
7. Person Centred Planning approach to be enhanced with external supports and education for staff on this model. This will be facilitated by an external organisation (Muiriosa Foundation) during January 2018.
8. Promotion of greater advocacy to support residents is currently being explored with members of the wider multidisciplinary team to support residents. Currently social work provide one to one advocacy to the centre. An enhanced model of advocacy support is being developed.

**Proposed Timescale:** 28/02/2018

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme: Effective Services**

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Written agreements viewed were unclear in relation to what services were provided to residents.

**11. Action Required:**
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be
charged.

**Please state the actions you have taken or are planning to take:**
1. Contract of care is being reviewed to ensure that all services provided are included in document.

| Proposed Timescale: 14/02/2018 |

**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:**
A comprehensive assessment from a social care perspective was not available when requested to reflect changes in need and circumstances for each resident at a minimum on an annual basis.

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

**Please state the actions you have taken or are planning to take:**
1. All residents in the centre will be assessed by a multidisciplinary team, including the medical personnel every 3 months.
2. All nursing assessments will be completed every four months. (In place and ongoing).

| Proposed Timescale: 30/04/2018 |

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some residents were not consulted in relation to their social care plan to ensure the maximum participation of each resident, and where appropriate their representative, in accordance with the resident's wishes and disability.

**13. Action Required:**
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

**Please state the actions you have taken or are planning to take:**
1. Individual plans will be re-assessed and reviewed annually at a minimum with each resident and their chosen representatives.
2. Individual plans will be developed through collaboration, communication and consultation with the resident and their chosen representatives, and will evidence that maximum participation of each resident was supported. Each resident will be given the option to attend this meeting if they choose to.

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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Effective arrangements to meet the assessed needs of each resident from a social care perspective were not evident.

14. **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. Residents will be supported in a consistent manner to achieve their goals by ensuring that arrangements are in place to continuously meet the assessed needs. The assessed needs will be identified to the team as a whole to include the Multidisciplinary team. All assessments will be reviewed by 30/04/18. All members of the team will be aware of and document goals in the Individual plan to ensure continuity. If issues arise which may hinder a person in achieving his/her goal, these issues will be identified and addressed in the individual plan and will be transparent to all the team as documentation will be recorded in one place – i.e. the individual plan. The resident will be supported throughout this process.

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**Outcome 06: Safe and suitable premises**

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The premises was not designed and laid out to meet the number and needs of residents.

15. **Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.
Please state the actions you have taken or are planning to take:
1. A new build plan is in place for 2021 on the site. It is anticipated that the disability services will then transfer to one of the vacated units on site. A decongregation plan is being developed in line with national policy.
2. No new admissions for residential and respite are being taken to the centre.
3. Communal space is being reviewed with residents to create more opportunities for privacy for residents.
4. Review of residents is taking place to establish if their needs could be met in other units on site, thereby reducing numbers in the designated centre.

**Proposed Timescale:** 30/06/2018  
**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:  
The premises were not kept in a good state of repair externally and internally.

16. **Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
1. Dining table covers have been replaced.
2. There are 2 large audits cleaning and hygiene (Annual Environmental Hygiene & Infection Prevention Control Audit) carried out annually and a mini hygiene audit once a month. The results of these audits will be displayed at ward level. The annual audit took place on 08/05/17 and 27/04/17 and the mini audits took place on 19/09/17 and 29/09/17.
3. External clean up of designated centre is being organised. Regular maintenance schedule to be devised thereafter to ensure external areas are kept clean.
4. Areas requiring immediate painting e.g. painting and on main corridor to commence on 18/12/17. Schedule of painting works to be established for 2018.

**Proposed Timescale:** 31/03/2018  
**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:  
The requirements of Schedule 6 were not met within the centre.

17. **Action Required:**
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
1. Communal space will be reviewed with residents to see if space can be utilised better to create more opportunities for privacy for residents and to allow adequate social, recreational, dining and private accommodation. This will be done by 28/02/18.
2. Each resident to be consulted regarding their personal space by their key worker.
3. Options around the provision of some kitchen facilities to residents for their use is being explored with a view to having a facility in place by 28/02/18.
4. A new build plan is in place for 2021 on the site. It is anticipated that the disability services will then transfer to one of the vacated units on site. A decongregation plan is being developed in line with national policy and will be developed before the end of June 2018.
5. No new admissions are being taken to the centre.
6. Review of residents has commenced to establish if their needs could be met in other units in site, thereby reducing numbers in the designated centre and allowing for increased personal space and storage for residents

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

**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 systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies required review.

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

**Please state the actions you have taken or are planning to take:**
1. Risk management policies are being updated and will be implemented by 31/01/18.
2. Risk assessments have been reviewed by the Quality and Safety Advisor for CHO 7 Social Care division Training will be provided for staff in writing and implementing risk assessments.
3. Fire officer was on site on 06/12/17, 25/01/18 and 26/01/18. Additional training has taken place to support staff in implementing practices.
4. Personal Emergency Evacuation Plans for each resident have been implemented.
5. Hi-vis jackets now on Lisbri and Elm to assist with the identification of staff in charge. All beds are tagged with blue or red tag to indicate level of mobility which will be identified in each residents Personal Emergency Evacuation Plan.
6. Monthly simulated evacuation drills commenced in January 2018 and will be documented in fire safety guidelines. Drills were carried out on 25/01/18 and 26/01/18 facilitated by the fire officer. 2 of these evacuations per year will be done at night time. Residents will be supported by staff to be involved in these and involvement will be documented on the fire safety register on the units.
7. Larger Floor plans are being erected on walls. This will be completed by 02/02/18.

**Proposed Timescale:** 02/02/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some containers for sharps did not contain a tagging system for identification purposes.

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

**Please state the actions you have taken or are planning to take:**
1. Sharps bins will be tagged immediately once bin has been commissioned for use.
2. These will also be included in waste management policy which is being revised.
3. A notice has been sent out to staff of change in practice. Training on Sharps Bin management and disposal was carried out in the centre on 18/12/17.

**Proposed Timescale:** 24/01/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations were not evident.

20. **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. HSE Fire officer was on site on 06/12/17, 25/01/18 and 26/01/18 providing additional fire training to support staff in implementing practices during fire drill.
2. Personal Emergency Evacuation Plans have been developed for each resident.
3. Additional fire evacuation drills took place on 25/01/18 and 26/01/18 facilitated by fire officer. These are documented at unit level with learning points documented.

**Proposed Timescale:** 02/02/2018

**Theme:** Effective Services
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements for maintaining of all fire equipment was not in place as some equipment was not serviced annually.

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

Please state the actions you have taken or are planning to take:
1. Fire blankets out of date have now been replaced.
2. A schedule for equipment maintenance is now in the fire safety register in the designated centres.

**Proposed Timescale:** 30/01/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Effective fire safety management systems were not in place within the designated centre.

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

Please state the actions you have taken or are planning to take:
1. Fire officer was on site on 06/12/17. Additional training planned on 21st December to support staff in implementing practices.
2. Personal Emergency Evacuation Plans are in place for each resident. All beds have been tagged with blue or red tag to indicate level of mobility which is identified in each residents Personal Emergency Evacuation Plan.
3. Fire doors were assessed by the fire officer on 30/01/18 and any required works will be actioned immediately.
4. Monthly simulate evacuation drills will commence from January 2018 and will be documented in fire safety guidelines. 2 of these evacuations per year will be done at night time.
5. Floor plans are being erected on walls and will be in place by 31/12/17.

**Proposed Timescale:** 28/02/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Fire safety management required improvement as fire drills at suitable intervals involving residents were not conducted.

Some staff spoken with were unclear of the process and the location of fire exits.

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

**Please state the actions you have taken or are planning to take:**
1. Monthly simulated evacuation drills commenced in January 2018 and are being documented in fire safety guidelines. However, additional training was provided on 25/01/18 and 26/01/18 following further HIQA inspection. 2 of these evacuations per year will be done at night time.
2. Template for recording procedure during fire drills has been amended

**Proposed Timescale:** 28/02/2018

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### 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:**
Incidents viewed within the complaints log and incidents recorded were not investigated as potential allegations or suspicions of abuse.

24. **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:**
1. Contact details of new designated officer now visible in designated centre, and is presently being supported by the CHO 7 safeguarding team in reporting all safeguarding issues, implementing risk assessments and appropriate action plans in conjunction with team. All staff are fully aware of her role and HIQA will be notified of all safeguarding incidents.
2. Weekly review of incidents to be carried out with PIC and provider nominee and key members of management and will be followed up accordingly.
3. 3 x NFO6 were submitted retrospectively on 10/11/17. These were discussed with the Principal Social Worker on the CHO 7 Safeguarding team on 04/12/17 and were not considered to be safeguarding matters.

**Proposed Timescale:** 31/01/2018
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors were unable to view any safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident’s personal plan and in a manner that respects the resident’s dignity and bodily integrity.

**25. Action Required:**
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
1. Intimate care policy has been revised to incorporate safeguarding and policy is available in the centre. Incontinence Training will be provided to staff during February 2018.
2. Trust in care training is organised for 29/01/18 and further training dates will be sought.
3. All safeguarding concerns will be investigated by the designated officer, risk assessments and action plans will be implemented thereafter. Safeguarding awareness training is on-going (3 sessions took place during December and January 2018 with a fourth planned for February 2018). Safe dignified care will be promoted in consultation with individual residents.

**Proposed Timescale:** 28/02/2018

**Theme:** Safe Services

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Residents were not protected from all forms of abuse.

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

Please state the actions you have taken or are planning to take:
1. A meeting was held on 04/12/17 with the Principal Social Worker, Provider Nominee, Person in Charge and Safeguarding Team CHO 7 to identify a safeguarding plan for the site.
2. A zero tolerance to abuse policy is being promoted across the site. This is being communicated in all units, to staff and service users.
3. Three additional designated officers have been identified for the site. These are the behavioural specialist CNM II and Campus manager with a third person (new ADON post) also expected to take on this role. They will participate in the next designated officer training being organised. Date to be confirmed.
4.3 Sessions awareness training for the site have taken place - 19th December, 11th January and 19th January will be facilitated by the safeguarding team. A fourth session is planned for February 2018. 2 staff members have been identified to participate in Train the Trainer safeguarding on site. One of these staff members is attending a Train the Trainer course in January. These people will also complete the Designated Officer training in order to fulfil the Train the Trainer requirements.

5. Local safeguarding policy is being updated to reflect changes in personnel as described above

6. Posters and leaflets on units now clearly visible

7. All communications – e.g. residents guide, visitors guide, open disclosure, complaints, risk management, code of behaviour, consent etc will be updated to reflect the revised safeguarding policy.

8. The process for developing a Safeguarding statement for the centre commenced on December 19th facilitated by the safeguarding team in conjunction with the staff. This will then be discussed with residents at resident meetings on completion.

9. Financial review of resident accounts will take place by 28/02/18 to ascertain if any financial abuse could have taking place in the administration of Patient Private Property Accounts on site.

10. Awareness training to residents to be facilitated by 28/02/18.


Proposed Timescale: 28/02/2018

Outcome 09: Notification of Incidents

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 within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of residents.

27. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
1. The incidents referred to were submitted by the PIC on 10/11/17.
2. All incidents will be reviewed on a weekly basis initially by the PIC / provider nominee/ nursing administration.

Proposed Timescale: 28/02/2018

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 within 3 working days of the occurrence in the designated centre of the unexpected death of a resident following transfer to hospital from the designated centre.

28. **Action Required:**
Under Regulation 31 (1) (a) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.

Please state the actions you have taken or are planning to take:
1. The NF01 was submitted on 10/11/18.
2. Education and guidance on notifiable events will be provided to the new proposed PIC by management commencing early January 2018.

**Proposed Timescale:** 28/02/2018

### Outcome 10. General Welfare and Development

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents had very limited access and support to opportunities for education, training and employment.

29. **Action Required:**
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
1. All residents will be reassessed by the MDT with a view to increasing access and support to opportunities for education, training and employment.
2. Promotion of greater advocacy to support residents is currently being explored with members of the wider multidisciplinary team.

**Proposed Timescale:** 30/04/2018

### 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:
Some plans of care in place for specific healthcare conditions, were not available. Therefore, staff members were not guided effectively and constantly in relation to the
management of all healthcare conditions.

One resident on the day of inspection did not receive any healthcare intervention for a specific condition.

30. **Action Required:**
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

**Please state the actions you have taken or are planning to take:**
1. All assessed healthcare needs will have a care plan in place by 28/02/18
2. The resident in question is known to the behavioural support specialist for the designated centre and was seen on 28/12/17 by her. Risk assessments have been reviewed by this specialist for this resident.
3. Pain assessment tool was implemented for this resident effective.
4. Medical review will be carried out by medical superintendent for the designated centre by 05/01/18.

**Proposed Timescale:** 28/02/2018

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents had limited access to snacks outside designated meal times.

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

**Please state the actions you have taken or are planning to take:**
1. Snacks to be made available to residents, and residents will be consulted about snack options. Catering were consulted on 18/01/18 about options for creating greater access to kitchen facilities.
2. Dietician to advise on healthy options for residents.

**Proposed Timescale:** 31/03/2018

**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:**
Capacity assessments had not been completed for residents in terms of their ability or wish to potentially take responsibility for their own medication.
32. **Action Required:**
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

**Please state the actions you have taken or are planning to take:**
1. Medical officer has devised capacity assessment for self-administration of medication. These have been completed with each resident.
2. Based on outcome of these capacity assessments a plan will be devised for individual residents. Those interested in self administration will be supported to do so by staff.

**Proposed Timescale:** 14/02/2018

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No guidance was available in relation to the administration of some PRN medicine

One administration chart did not contain a photograph of the resident from the sample viewed

The writing within the medication charts viewed were illegible.

Medication required to be returned to the pharmacy remained within the centre.

33. **Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
1. New medication policy is almost operationalized. New Kardexes and emergency epilepsy bags have been ordered. Once these arrive policy can be operationalized. This will facilitate more detail around PRN medication.
2. All charts now have photographs of residents.
3. Medication has been returned for the deceased resident.
4. Illegible Kardexes have been re-written and prescribing doctors have been spoken to by the medical officer.

**Proposed Timescale:** 14/02/2018

**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:
Copies of the current statement of purpose was not available to residents and their representatives at a unit perspective.

**34. Action Required:**
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

**Please state the actions you have taken or are planning to take:**
1. Staff are being made aware of statement of purpose and what it contains
2. Accessible version of statement of purpose to be prepared with consultation of residents
3. Copies of both versions to be readily available for residents and families.

**Proposed Timescale:** 28/02/2018

**Theme:** Leadership, Governance and Management

The statement of purpose did not fully meet the requirement of schedule 1 of the regulations.

**35. Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
1. The statement of purpose is currently being reviewed by the provider nominee and incoming Person in Charge to ensure it contains the information contained in Schedule 1. This will be completed by 31/01/18.

**Proposed Timescale:** 31/01/2018

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

The person in charge was also the person in charge of another designated centre and effective governance, operational management and administration of this centre was not evident.
36. **Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
1. NF30 will be submitted to change the Person in Charge to CNM II with responsibility for the designated centre only.
2. Mentorship will be provided to the incoming Person in Charge from Muiriosa Foundation.
3. An additional senior nursing resource with significant nursing experience in managing a previous designated centre is also commencing in the designated centre from 04/01/18. This will assist the incoming Person in charge in ensuring effective governance, operational management and administration of the designated centre.
4. The incoming Person in charge will also attend all relevant committees and groups to ensure that communication is available in a timely manner to facilitate the effective management of the designated centre.
5. Any other identified training or support needs will be met by the registered provider.

**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:
Accurate copies of the report of the unannounced visit to the designated centre were not available on request to residents and their representatives and the chief inspector during the inspection.

37. **Action Required:**
Under Regulation 23 (2) (b) you are required to: Maintain a copy of the report of the unannounced visit to the designated centre and make it available on request to residents and their representatives and the chief inspector.

**Please state the actions you have taken or are planning to take:**
1. Staff will receive training on the purpose of this document.
2. Old copies have been removed and up to date version will be available only.
3. Copy will be made available to residents and their representatives and findings discussed with them through ward meetings.

**Proposed Timescale:** 09/02/2018

**Theme:** Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory
requirement in the following respect:
Effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they delivered was not in occurring within the centre.

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

Please state the actions you have taken or are planning to take:
1. Incoming Person in Charge will receive mentoring and support from an external organisation, line management structures and provider nominee. An additional senior nurse will also be present on the units two days per week to provide support and direct feedback to the Person in Charge and other staff on the units. This will commence from 04/01/18.
2. CNM I on one of the units has been enrolled in a 3 day management and leadership course which commenced on the 23rd January 2018.
3. The incoming Person in Charge and CNM I are also enrolled in a foundation Course which commenced on 10th January 2018 which looks at relevant topics such as person centred planning, leadership and promoting communication.
4. The ADON with responsibility for the units and CNM II will implement Personal Development Plans for staff who were unable to respond appropriately to HIQA inspectors commencing in January 2018.
5. Increasing the management presence on the units will also facilitate direct feedback and guidance immediately to all staff in the centre. This will formally commence on 04/01/18.
6. Educational needs analysis carried out annually and education programme is based on needs identified by the staff themselves. This is currently underway by the education officer and will be completed by 31/01/18.
7. Daily handover to be used as opportunity to discuss standards, areas of concern re regulations, safety pause to reinforce and support all staff around their professional responsibilities. This has commenced.
8. Person Centred Planning workshop scheduled for January 2018 will assist with identifying further training needs.
9. Education on policies to be provided as new policy is introduced to the designated centre.
10. NMPDU courses are offered on a continuous basis, and staff are supported both time wise and financially.

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 management structure in the designated centre did not clearly identify the lines of
authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

**Please state the actions you have taken or are planning to take:**
1. NF30 will be submitted to change the Person in Charge to CNM II with responsibility for the designated centre only. This person is supernumery.
2. Mentorship will be provided to the incoming Person in Charge from Muiriosa Foundation, current nursing line management and by the provider nominee to support her in this role.
3. An additional senior nursing resource with significant nursing experience in managing a previous designated centre is also commencing in the designated centre from 04/01/18. This will assist the incoming Person in Charge in ensuring effective governance, operational management and administration of the designated centre.
4. Incoming Person In Charge will report to current ADON for all nursing issues effective immediately who in turns reports to the Director of Nursing.
5. Incoming Person in Charge will report to provider nominee for all non-clinical issues effective immediately.
6. The incoming Person in charge will also attend all relevant committees and groups to ensure that communication is available in a timely manner to facilitate the effective management of the designated centre.
7. Any other identified training or support needs identified by any of the above will be met by the registered provider.
8. The provider nominee reports to the Head of Social Care, CHO 7.
9. The disability management team that currently meets is reviewing the format and membership of this meeting to ensure that all aspects of Regulation 23 (1) (b) are being addressed. This will be done in the February meeting scheduled for which

**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 management systems in place in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

40. **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. NF30 will be submitted to change the Person in Charge to CNM II with responsibility for designated centre only.
2. Mentorship will be provided to the incoming Person in Charge from Muiriosa Foundation.
3. An additional senior nursing resource with significant nursing experience in managing a previous designated centre is also commencing in the designated centre from 04/01/18. The incoming Person in charge will also attend all relevant committees and groups to ensure that communication is available in a timely manager to facilitate the effective management of the designated centre.
4. Any other identified training or support needs identified by any of the above will be met by the registered provider.
5. The provider nominee reports to the Head of Social Care, CHO 7.
6. The disability management team that currently meets is reviewing the format and membership of this meeting to ensure that all aspects of Regulation 23 (1) (b) are being addressed. This will be done in the February meeting.
7. The provider nominee will spend one day per week on site commencing 04/01/18.
8. A schedule of unannounced provider visits will be put in place by a team comprising of disability manager and quality and safety advisor to CHO 7 which will focus the standards and regulations to ensure effective and consistent monitoring of the service. The Person in Charge will be given feedback and a clear action plan will be put in place on the findings of these audits. This will commence week of 07/01/18. All visit findings will be visible on the units.
9. A project team has been established to address the findings of this inspection and to regulatory compliance issues, comprised of key personnel for the units. This group are now meeting fortnightly.
10. The Quality and Safety Advisor to CHO 7 Social Care has commenced a review of risk management policy and risk assessments with staff.
11. Risk assessment training is scheduled for 06/02/18 for staff in the designated centre.
12. Monthly designated centre unit meeting set agendas will include risk, incidents, learning from HIQA, resident concerns

Proposed Timescale: 28/02/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The actual rota was not accurately maintained within the designated centre to reflect the actual staff members present.

One member of staff had to assist in another unit on campus, this was not reflected on the rota.

The times of shifts were not documented on the night rota.
41. **Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
1. The rota has been amended to reflect the correct staffing levels at night. The units will be aware of who is on the roster for that night in advance. The night manager for the site is now communicating and documenting on ward off duty the name of the second nurse on duty to facilitate residents awareness of who will be working each night.
2. Assistance to the other unit is no longer in practice.

**Proposed Timescale:** 11/12/2017

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff members required refresher training in a number of areas as outlined in the body of the report.

42. **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:**
1. An audit of staff training has been carried out and all training records up to date.
2. All training records, both mandatory and non-mandatory training will now be kept at unit level in conjunction with nursing administration. According to records, 100% of staff in the designated centre had attended MAPA training, 100% of staff had attended manual handling training, 95% of staff had attended CPR and 95% of staff had attended fire training at 31/12/17.
3. Appropriate training is offered as part of training schedule available to staff in the designated centre.
4. Educational needs analysis has been done and data is being correlated as part of staff continuing personal development programme.

**Proposed Timescale:** 28/02/2018

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff members were not knowledgeable in relation to the Act and the regulations and standards from a disabilities perspective.
43. **Action Required:**
Under Regulation 16 (1) (c) you are required to: Ensure staff are informed of the Act and any regulations and standards made under it.

**Please state the actions you have taken or are planning to take:**
1.2 day workshop on the Health Act, regulations and standards has been provided by the Muiriosa foundation on 4th and 6th December 2017. This was attended by disability staff, health and social care professionals. 2 further dates are planned for March 2018.
2.Unit meetings will also regularly discuss an aspect of the Act and regulations and how it applies in practice. A record of this will be kept on each unit.

**Proposed Timescale:** 31/03/2018

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**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:**
Several policies and procedures were not reviewed at intervals not exceeding 3 years as identified within the main body of this outcome.

44. **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:**
1. All policies are being addressed and updated if identified as exceeding 3yrs.
2. New policy folders will be implemented which will facilitate greater accessibility by staff.
3. A new database is being compiled will clearly identify when policies require updating.

**Proposed Timescale:** 28/02/2018

**Theme:** Use of Information

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Some policies were not available within the designated centre and others were not developed as outlined in the main body of this outcome.

45. **Action Required:**
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
Please state the actions you have taken or are planning to take:

1. All Schedule 5 policies are all being reviewed. Education around these folders and programme for implementation being devised education officer. All policies will have to be read on an annual basis and signed off by staff. New database being devised by education officer and template is in the process of being completed whereby it will list all policies and which staff have read and signed them. This will be sent to manager monthly for updating and will act both as an accurate recording tool and reminder for managers of specific staff and relevant policies they are required to update themselves on.

2. CCTV policy is being developed and will be completed by 28/02/18.

3. Recruitment, selection and garda vetting of Staff policy was available in Nursing Administration on the day of the inspection, but is now available in the centre.

4. Management of a missing resident was reviewed in 2017 and is now available in the centre.

5. Risk management policy will be implemented by 31/01/2018.

6. Visitors policy was implemented 19/01/2018.

7. Provision of behavioural support policy is completed. Education will be provided in February 2018 as the CNS has developed a new risk behaviour package (included in policy) which will be piloted in January. This policy will be fully operational by 28/02/18.

8. Medication Management policy is completed. New Kardex has been devised for safer practices and will be fully operational by 31/01/18.

9. Staff training and development policy will developed and operational by 28/02/18.

10. Communication with residents policy will be completed by 28/02/18.

11. Complaints policy will be reviewed by 28/02/18 to reflect changes to national policy and adaptation for local use in the centre.

Proposed Timescale: 28/02/2018

Theme: Use of Information

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

The directory of residents required improvements to ensure the information specified in Schedule 3 were included such as, the name of resident’s general practitioner.

46. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

1. Directory of residents has been updated to include all information as set out in Schedule 3 and is available on hard copy on the units, including details of either GP or medical superintendent details.
**Proposed Timescale:** 02/01/2018