Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Cherry Orchard Hospital
Centre ID:	OSV-0003730
Centre county:	Dublin 10
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Marie Byrne
Support inspector(s):	Ciara McShane
Type of inspection	Announced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	6

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
10 September 2018 09:00	10 September 2018 17:00
10 September 2018 09:00	10 September 2018 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the seventh inspection following the providers' application to register the 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. As a result of the concerns during previous inspections of this centre, notices of proposal to cancel the registration and refuse the renewal of registration of the designated centre were issued. A representation document was submitted to the Health Information and Quality Authority (HIQA) by the registered provider following the issuing of the notices of proposal. The provider was then engaged in an escalated six month regulatory plan outlining how they would come into compliance. As part of the six month regulatory plan the provider was required to submit monthly assurance reports and met with representatives of HIQA frequently to present updates regarding their assurance report.

This inspection looked at how the providers' assurance report was impacting on the service provided and to determine if it was driving change and improvement. The inspectors found that overall, although at its infancy, the provider was implementing their improvement plan. The inspectors found that consequently the providers' strengthened governance and management arrangements were beginning to have a positive impact of the lived experience of residents.

Post inspection, the provider submitted further plans for future service provision

which ultimately would enhance the lives of residents.

How we gathered our evidence:
During the inspection, inspectors met and spoke with the key stakeholders identified on the centres' revised statement of purpose. These stakeholders included the registered provider representative, four persons participating in the management of the designated centre, six staff members and the organisations' quality and risk advisor. The inspectors met with one resident and their family member. The inspectors made observations throughout the inspection day which demonstrated how staff interacted and supported residents. The person in charge was on leave during the inspection.

Description of the service:
The designated centre is based in Dublin and operated by the Health Service Executive (HSE). The centre consists of two buildings in close proximity to each other, within a hospital campus. Care is provided for 26 residents over the age of 18, both male and female with a disability and includes six respite beds. Support is provided to residents over a 24 hour period by registered nurses and healthcare assistants. In addition eight social care workers have now commenced in post.

Overall judgments of our findings:
During this inspection there was evidence that the revised governance and management systems and structures, although at its' infancy, had begun to bring about aspects of positive change for residents. The management structure had recently been reviewed and there were now clearly identified lines of authority and accountability. Staff members' roles and the details of their responsibilities for the areas of service provision were now clear. On the previous inspection effective governance, operational management and administration of this centre was not evident. On this inspection improvements were found and there had been increased oversight and monitoring over the last number of months including the unannounced provider visits. However, this was at its infancy and further improvements and sustained improvement was still required to be evidenced to ensure safe, consistent and effective delivery of care in accordance with residents' needs. The provider had brought in external expertise which had assisted with this improvement.

The inspectors found that residents, albeit not optimal, now had increased access to allied health professionals and that some improvements had occurred in relation to their activity levels and access to the community. In addition some improvements were noted in relation to residents' privacy and dignity due to works which had been completed. Safeguarding procedures had been strengthened with a new designated officer in place who was solely responsible for safeguarding in the centre. The inspectors also found that staff had an increased awareness of safeguarding and what to do if there was a concern. Improvements were also noted to risk management and incident review.

Although efforts had been made to make the premises more homely, such as pictures and soft furnishings, concerns remained in relation to the suitability and fitness for purpose of the building. The premises remained clinical in layout with multi-occupancy rooms and insufficient space for storage of residents' personal

items. The building was not conducive to the number and needs of residents. The inspectors found that the provider was at the start of a journey and at the early stage of bedding down the change which was yet to have a full impact on the overall lived experience for residents.

Areas of progress and findings of this inspection are discussed within the body of this report and the regulations which are not being met in the action plan at the end of the report.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Overall, the inspectors found that residents' privacy and dignity were not upheld at all times as they continued to be compromised due to the design and layout of the premises including multiple occupancy bedrooms. Some residents did not have adequate storage for personal belongings in shared bedrooms. The provider had put measures in place to complete some of the actions outlined by them following the last inspection.

Works had been completed to place a partition wall in one of the multiple occupancy bedrooms and plans were in to place for a similar partition wall in another multiple occupancy bedroom. The provider had reduced the bed capacity to 26 since the last inspection which led to one resident moving from a multiple occupancy bedroom to their own bedroom. Works had also been completed to install a swipe access system to the front door of one premises which had positively impacted residents due to a significantly decreased footfall and noise levels. Only residents and staff had access to swipe cards, and all other visitors now had to ring the doorbell and wait for assistance to enter the premises. Frosted privacy sheets had also been placed on bedroom windows since the last inspection.

Residents' meetings were continuing which were chaired by residents. There was a schedule of planned meetings developed for the year and an agenda was circulated in advance of each meeting. An advocacy group had recently commenced which was facilitated by the additional social worker who was now in post. Information was available for residents in both premises in relation to available advocacy supports. A project group were meeting fortnightly to review updates and actions from the

environmental group and the residents' survey group. They were also reviewing accessible information required for residents. Actions from the residents' survey were progressing and a number of planned information sessions for residents including talks and demonstrations on medication, on exercise by the physiotherapist, on diet and nutrition by the dietician. In addition Dublin bus were bringing a bus on site to assist residents' in understanding and accessing their services.

Six quality of interactions audits had now been completed. These audits reviewed interactions between residents and staff. The findings of this audit were mostly positive with good communication and social interactions between staff and residents. Immediate feedback was given during these audits by the auditors to staff when required. Areas for improvement were identified. These included the need for staff to communicate effectively with residents when; placing food in front of resident, when adjusting residents' position during mealtimes, and in relation to informing residents where they were going if they were leaving them to get something. Recommendations were developed and a plan was in place to implement these.

A number of resident and their representatives completed questionnaires prior to this inspection. Overall, the feedback in these questionnaires was positive and residents and their representatives were particularly complimentary towards staff. There were many positive comments towards how helpful and friendly staff were and how welcome they make visitors feel. Positive feedback was also given in relation the care and support for residents, the food, the outdoor spaces, how warm and comfortable the centre was, and the management of complaints. Areas for improvement were identified such as staffing levels at times, the temperature of meals, residents' availing of opportunities to buy their own drinks and snacks, and more opportunities to partake in activities 1:1 with staff rather than in a group particularly when accessing the community.

During the inspection, the inspectors observed elements of residents' daily lives including mealtimes and activities. Through observation the inspectors found that interactions between residents and staff were positive. Residents were observed to be treated with dignity and respect. Through discussions and review of documentation the inspectors found that improvements were required in relation to some residents access to activities in line with their interests and wishes, particularly relating to accessing their local community.

A local complaints officer had been identified and their contact details were available in both premises. A complaints audit had been completed and recommendations were in the process of being actioned. 100% of staff had completed HSEland online complaints module. The complaints procedure was now available in an accessible format and on display.

Judgment:
Non Compliant - Major

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:
Overall, the inspectors found that improvements had been made in relation to residents' social care needs. An external provider had supported the provider with reviewing the assessed needs of all residents. Improvements had also occurred in relation to residents' opportunities to participate in meaningful activities. However, some residents did not have opportunities similar to their peers and had limited access to their local community. The inspectors acknowledged that there had been an increased focus on residents' social care needs in the centre and eight social care workers including two team leaders, who were on secondment, were now working in the centre. However, social care goals were in their infancy and required development to further enhance quality of life outcomes for residents. The social care team were also in their infancy and required more time to evolve their roles.

Care plan audits had been completed and plans were in place to complete the required actions following these reviews. Each resident's assessment of need had been reviewed and it had been identified that a number of residents' care and support needs were currently not being met. The provider was in the process of adapting a social care model and had introduced new personal plans based on this. However, these personal plans were in the infancy stage and yet to fully impact residents' daily lives. Each resident had now had a multidisciplinary team meeting and plans were in place for these to be held six monthly. An accessible leaflet had been produced to explain these meetings. Education had been provided to staff in relation to completing personal plans in a person-centred manner by an external provider and more of this training was planned.

Residents were accessing a range of activities on site with the support of an activities team and the staff team. There was an increase in home and community based activities for a number of residents since the last inspection. A weekly activities planner and a daily activity log were in place. Residents were being supported to partake in 1:1 or group activities including arts and crafts, board games, and meaningful activities in the community. A directory of activities in the local community was available for residents to access independently or with the support of staff. A seven seater vehicle had recently been sourced and was now available for residents to engage in activities in the community. During the inspection, inspectors observed this vehicle being used by residents to access meaningful activities. In addition during the inspection members of

the management and staff team described the impact that this vehicle was having for a number of residents who previously did not wish to engage in activities outside of the centre. From speaking with a number of staff in the centre it was clear that improvements had been made in relation to residents' access to meaningful activities. However, improvements were still required in relation to the level of activity for some residents and the opportunities for residents to partake in 1:1 activities in the local community.

Judgment:
Non Compliant - Moderate

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:
Overall, in line with the findings of the last inspection the premises was not found to be fit for purpose. The design and layout was not meeting residents' individual or collective needs. The inspectors found that both premises were clean and well maintained during the inspection. The inspectors acknowledge that works had been completed since the last inspection which had resulted in improvements for a number of residents.

The inspectors found that the requirements of schedule 6 of the regulations were not being met in the centre. The centre remained compromised in relation to the layout and design and residents' privacy and dignity was still being compromised in relation to multiple occupancy bedrooms. These bedrooms were not of a suitable size or layout to meet residents' needs and some residents did not have adequate storage space for their personal items. Communal space was clinical in its layout and not appropriate to meet residents' needs. The inspectors also acknowledge that improvements had been made to attempt to make the premises more homely by painting areas, moving furniture around to better suit residents' needs and adding soft furnishings and pictures. In addition there were more personal items such as photos and pictures in residents' rooms and throughout both premises.

Some improvements since the last inspection included works to put up a partition wall in one of the multiple occupancy bedrooms. The provider described plans to complete similar works in another multiple occupancy room. One resident had moved from a

multiple to a single occupancy bedroom since the last inspection and the bed capacity had been reduced from 27 to 26. One resident had expressed their wish to move home and this was being explored with the support of their social worker.
Laundry facilities were available for residents use if they so wished. There were suitable arrangements in place for the safe disposal of general and clinical waste.

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:
Overall, inspectors found that improvements had been made in relation to measures in place to protect residents being harmed or suffering abuse. A weekly review of incidents was now occurring with the person in charge, the acting assistant director of nursing and the quality and risk advisor. A safeguarding algorithm has been developed and a National Incident Management System (NIMS) flowchart to clearly guide staff what steps to take if there was a safeguarding concern. In addition Garda vetting was now in place for all staff and they had all received safeguarding training. The inspectors found that improvement was still required in relation to behavioural and therapeutic support for residents.

Safeguarding procedures have been strengthened since the last inspection. A new designated officer has been trained who was solely responsible for safeguarding in the centre. 100% of staff had now completed safeguarding training. The inspectors also found that staff had an increased awareness of safeguarding and what to do if there was a concern. In addition, the clinical nurse manager in behaviour has completed safeguarding information sessions with residents. Residents' intimate care plans have been reviewed and updated in line with their individual preferences. In line with learning following incident review a new template was being utilised which included a section for follow up an escalation of incidents to relevant members of the multidisciplinary team.

The clinical nurse specialist had identified which residents required assessment and

support in relation to their behaviour support needs. Some training has been provided for staff and more was planned. In addition a workshop is in development between the clinical nurse manager and speech and language therapy department in relation to communication and responsive behaviour. Through discussions with staff in relation to incident review and escalation the inspectors found that improvements were still required in relation to staff recognising, responding to, appropriately reporting and escalating incidents relating to residents' challenging behaviour. They were in the process of working with residents and the relevant staff to develop and implement responsive behaviour care packs for 12 residents. Ten of these behaviour care packs have been completed to date with the remainder to be completed by the end of 2018. Therefore, there was insufficient guidance in place for staff to support some residents with their behaviour support needs.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall, the inspectors found that the management structure in the designated centre had recently been reviewed and strengthened. There were now clearly identified lines of authority and accountability and staff members' roles and the details of their responsibilities were now clear. However, the inspectors found that improvements were still required in relation to the day-to-day oversight and monitoring of the centre to ensure residents were in receipt of a good quality of care and support in the centre. Inspectors recognised that whilst some progress had occurred since the last inspection in relation to the quality of care and support for residents, these changes were yet to fully impact and enhance their quality of life.

On previous inspections significant improvements were required in the area of oversight of service provision to ensure safe, consistent and effective delivery of care. On this inspection improvements were found in relation to oversight of service provision. However, the inspectors found that improvements were still required. The provider

representative was visiting the centre at least weekly and there had been an increase in management presence over the last number of months including the unannounced provider visits. Members of the management team were completing management and safety walk arounds. Audits were being completed regularly in the centre and an overall audit review had been completed to review required actions. The audits completed regularly included care plan audits, financial audits, complaints audits, hand hygiene audits, and medication audits. Action plans were developed and some had been completed with plans in place to complete the outstanding actions. There was a project team who were meeting fortnightly. In addition, there were monthly management team meeting and weekly meetings to review incidents and accidents.

As part of the six monthly regulatory plan, which commenced in February 2018, the provider was submitting monthly assurance reports. There was an oversight committee who were meeting weekly to review required actions as part of this assurance reporting. They were using a quality improvement tracker to track progress against their action plans from previous inspections by HIQA. Of the 166 actions identified by the provider following the inspection in November 2017, 94% were identified as completed, 3% were underway and 1% had not reached their completion date. Of the 74 actions identified by the provider following the inspection in January 2018, 93% were identified as completed, 3% were overdue and 1% had not reached their completion date. Of the 68 actions identified by the provider following the inspection in March 2018, 91% were identified as completed, 9% were outstanding. Of the 77 actions identified by the provider following the inspection in May 2018, 71% were identified as completed, and the remaining 29% were outstanding.

A new person charge was put in place in April 2018 with sole responsibility for the centre. On the previous inspection effective governance, operational management and administration of this centre was not evident. On this inspection improvements were noted in relation to the governance and management of the centre. The provider has delegated the responsibility for the day to day management of the centre to the person in charge who was supported on a day to day basis by two clinical nurse managers. They were also supported by four persons participating in management of the designated centre (PPIM). One PPIM was a director of nursing, two were assistant directors of nursing and one was an acting assistant director of nursing. Each of the PPIMs had defined roles and responsibilities within the centre and demonstrated detailed knowledge of the service provided in conversations with the inspectors.

The acting assistant director of nursing was now line manager for the person in charge. They were meeting weekly at the oversight committee meeting and meeting formally once a month. They had a set agenda for their monthly meetings which included discussions in relation to action plans, training, quality and risk, safeguarding, complaints, human resource and industrial relation issues.

Judgment:
Non Compliant - Moderate

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:
Overall, the inspectors found that improvements had been made to staffing numbers and the skill mix of staff since the last inspection. There were no staffing vacancies on the day of the inspection. However, the new staffing arrangements were just taking effect and yet to fully impact on residents' quality of life. The inspectors acknowledge that improvement had occurred in relation to staff accessing training. However, a number of staff did not have training in line with residents' needs and were not being supervised appropriate to their role.

The provider had reviewed the skill mix of staff and eight social care workers were now working in the centre. In line with the reduction of resident numbers and the move from a medical model to a social care model of care, the nursing skill mix was also reviewed and changes made. In addition, a number of staff had completed, or were being supported to complete additional social care qualifications and some had plans to complete further training such as; a MSc in rehabilitation and disability studies, a diploma in leadership and quality in healthcare, a MSc in ageing, health and wellbeing in intellectual disabilities and the national programme to enhance cultures of person centeredness across the HSE.

Whilst improvement had been made since the last inspection in relation to staff training, gaps remained. Further training was scheduled to include, training relating to regulation, fitness to practice, documentation and care planning. The inspectors reviewed the centres' training matrix and found that 100% of staff in both units had now completed infection control, complaints, CPR, medication management, manual handling and safeguarding training. In one unit 100% of staff had completed fire safety training and in the other 100% had completed MAPA training and communication with a resident with an intellectual disability training. The training gaps identified in one unit were that 5% of staff required MAPA training, 81% required risk assessment training, 40% required communication with a resident with an intellectual disability, 60% required responsive behaviour training, and 15% required incident report and management training. In the other unit 8% of staff required fire safety training, 64% required responsive behaviour training, 15% required incident reporting training, and 70% required risk assessment training.

Plans were in place to complete supervision for all staff and some training had been

provided and more was planned. Templates were developed in conjunction with the training and development officer for use as part of the supervision process. They included personal development plans for staff, support and supervision agreements, and a support and supervisory record. The process included a competency review completed by the staff and their line manager and an overall review and actions required including those for addressing concerns if required. Different competency frameworks and documents were in place for different grades of staff. However, the inspectors found that this process was in its infancy and only as small number of supervisions had been completed. Therefore, as yet effective arrangements were not in place to support, develop and performance manage all members of the workforce.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Marie Byrne
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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003730
Date of Inspection:	10 September 2018
Date of response:	06 December 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:
Residents' privacy and dignity were being compromised due to their personal and living space.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

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:
Creation of individual spaces in two multi-occupancy rooms is well progressed. One room has been completed and the second room is underway with a completion date of 05/11/18. A private space for accessing a PC has been created in the dining area for resident use only.

Proposed Timescale: 05/11/2018

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that some residents did not have adequate space to store their personal property and possessions.

2. 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:
Additional storage facilitates will be sourced for residents as required.

Proposed Timescale: 30/11/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that improvements were required in relation to some residents' opportunities to participate in activities in line with their wishes and that some residents required support to develop links in their local community.

3. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
Opportunities for residents to engage in individual activities of their choosing continue to be explored with residents in accordance with their person centred plans. Social care workers are working with residents and the multidisciplinary team

Proposed Timescale: 30/11/2018

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:
Care and personal plan audits had been completed and actions developed. These actions were progressing but not yet complete for all residents.

4. 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:
Multidisciplinary team meetings continue to take place for all residents. All professionals on the MDT are now present and attend these meetings. Follow up actions are being reviewed regularly to ensure that progression is occurring.

An audit of every care plan including personal plans has been carried out; actions based on the outcome of the audit have been carried out.

Proposed Timescale: 30/11/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some residents' goals were in their infancy and yet to fully impact their daily lives. Some residents had limited opportunities to access community based activities in line with their wishes.

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

Please state the actions you have taken or are planning to take:
Developing community links which are appropriate are ongoing and are being developed on an individual basis in line with goals identified in person centred plans.

Proposed Timescale: 30/11/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that the centre was not suitable to meet the needs of each residents in line with their assessment of need.

6. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
A new build plan is in place for 2021 on the site. It is anticipated that disability services will then transfer to one of the vacated units on site which will meet the requirements of Schedule 6. HSE Estates have explored options around the design and layout of the bedrooms. Creation of individual spaces in two multi-occupancy rooms is well progressed. One room has been completed and the second room is underway with a completion date of 05/11/18.

A full transition plan was submitted to the regulator which sets out the future plan for the service, which will be implemented by 31/10/2021. This includes a plan for decongregation for a number of residents. An Expression of Interest is currently underway with organisations to explore suitability of organisations to undertake this work on behalf of the HSE. The initial phase of this process is concluding on 25/10/18.

Proposed Timescale: 31/12/2021

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that the design and layout of the premises did not meet the number of needs of residents.

7. 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:
A new build plan is in place for 2021 on the site. It is anticipated that disability services will then transfer to one of the vacated units on site which will meet the requirements of Schedule 6. HSE Estates have explored options around the design and layout of the bedrooms. Creation of individual spaces in two multi-occupancy rooms is well progressed. One room has been completed and the second room is underway with a completion date of 05/11/18.

A full transition plan was submitted to the regulator which sets out the future plan for the service, which will be implemented by 31/10/2021.

Proposed Timescale: 31/10/2021

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that the requirements of schedule 6 of the regulations were not being met.

8. 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:
A new build plan is in place for 2021 on the site. It is anticipated that disability services will then transfer to one of the vacated units on site which will meet the requirements of Schedule 6. HSE Estates have explored options around the design and layout of the bedrooms. Creation of individual spaces in two multi-occupancy rooms is well progressed. One room has been completed and the second room is underway with a completion date of 05/11/18.

A full transition plan was submitted to the regulator which sets out the future plan for the service, which will be implemented by 31/10/2021

Proposed Timescale: 31/10/2021

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:
A number of residents identified as requiring behaviour support did not have responsive behaviour packs in place.

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

Please state the actions you have taken or are planning to take:
The outstanding behavioural supports packs will be completed by the CNS in behaviours.

Proposed Timescale: 30/11/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that improvement was still required in relation to the day-to-day oversight and monitoring of the centre. Strengthened arrangements were in place since the last inspection but they were in their infancy and yet to impact fully on residents' lived experiences.

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

Please state the actions you have taken or are planning to take:
The structures in place at the time of the inspection continue to be implemented and monitored by the management team e.g. oversight meetings with Head of Social Care, regular incident review meetings by the Person in charge and A/ ADON overseen by the Quality & Risk Advisor, management presence on site, including management walkabouts, supervision meetings between the Person in Charge and nursing line management, and Person in Charge with provider nominee for non- clinical matters. Supervision sessions have commenced and all staff have received at least one supervision session or plans are in place to commence the process.

Proposed Timescale: 31/12/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that effective arrangements were not fully in place to support, develop and performance manage staff in the centre.

11. 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:
The training and development officer has designed a set of competencies to ensure that each staff member has the knowledge and skill appropriate to their role. All supervisors are advised to complete supervision training module on HSE land. The training and

development officer continues to support staff in this process.

Proposed Timescale: 31/12/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that some staff had not completed training or refreshers in line with residents' needs as outlined in the body of the report.

12. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
All efforts are being made to ensure that all training requirements as identified are met.
Training was provided by NMBI on best practice in nursing and midwifery documentation in conjunction with a fitness to practice on the 9/10/2018.
Open Disclosure Training is taking place on 10/12/2018.
Oral hygiene care champions from both units are being trained on the 30/10/2018 to provide support and education to all other staff members on this specific aspect of care.
A communication workshop with Speech and Language therapy is planned over the coming weeks.
Dignity at work (New Module) HSEland- all staff requested to complete.
100% of staff on Elm have completed training in communicating with people with an intellectual disability on HSELand. 90% of staff have completed it on Lisbri.
A third and final date for training for staff on person centred planning is being arranged as the date scheduled for 29/09/18 was postponed.
Supervision meetings will address and action further education deficits

Proposed Timescale: 31/12/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that all staff were not yet in receipt of formal supervision.

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

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

All supervisors are required to complete professional supervision module on HSEland prior to commencing the supervision process. 1 is currently outstanding. Supervision meetings are well underway and there is a schedule for the remainder of the year for all staff in the designated centre.
Proposed Timescale: 31/12/2018