

**Health Information and Quality Authority
Regulation Directorate**

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



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:	Karina O'Sullivan
Support inspector(s):	Thomas Hogan
Type of inspection	Unannounced
Number of residents on the date of inspection:	25
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
23 January 2018 08:40	23 January 2018 17:30
24 January 2018 10:00	24 January 2018 15:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

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. A further inspection took place on the 09 November 2017. Significant breaches with the regulations were identified. Following the inspection HIQA issued the provider representative and the person in charge with a notice of proposal to cancel and to refuse the registration of this centre on 06 December 2017. As a result HIQA received representation from the organisation on the 04 January 2018. This inspection was conducted to establish if the measures outlined in the representation

plan and the action plan from the previous inspection were implemented and impacted positively on residents' lives. However, the finding identified that out of 46 breaches found in November 2017, 37 of these were also found in January 2018. Therefore, 86% of the breaches were repeatedly found. Inspectors did acknowledge improvements were occurring. These were at an early stage of implementation and required further time to become fully operational and thus come into compliance within the regulations.

How we gathered our evidence:

As part of the inspection, inspectors visited the designated centre, met with 18 residents and spoke with the provider, person in charge and 13 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 10 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. 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 27 residents.

Overall judgments of our findings:

Some changes leading to improvement had occurred since the previous inspection, it remained that the provider was in significant non compliance with the regulations. Sufficient progress was not evident in order to bring about compliance with the regulations and improve residents' experience of living in the centre. The 10 outcomes found in major non-compliance with the regulations remained unchanged during this inspection, with a further outcome in relation to healthcare also increasing in the level of non compliance to major. One decrease in the levels of non-compliance occurred in relation to workforce. Inspectors acknowledged systems were identified in relation to changes in practice, however, at the time of this inspection these were not fully operational or effective in relation to enhancing the quality of lives of residents. Eleven outcomes were found to be major non compliant:

Outcome 1: Residents rights, dignity and consultation

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 12: Medication Management

Outcome 11: Healthcare

Outcome 14: Governance and management

Outcome 18: Records and documentation

The remaining four 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:

Inspectors found the eight actions identified by the provider following the last inspection had not been fully implemented. However, inspectors acknowledged the proposed timescale had not passed.

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. Inspectors also observed that some residents had inadequate space to store and maintain their clothes and personal property and possessions.

As with the previous inspection findings significant improvements remained 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.

Inspectors observed routines during this inspection and also during the previous inspection which were task orientated and practices which did not promote residents' independence or choice. Consultation with residents was 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 asleep in bed, yet, their bedroom doors were open and other staff members and residents were walking up and down the corridor.

Inspectors found some residents did not participate in decisions about their care, this was illustrated through minutes of a multi disciplinary meeting viewed since the previous inspection. In addition consultation with residents in relation to the organisation of the centre was also very limited.

Inspectors viewed the complaints log within the centre. Improvements were still 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):

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

Findings:

Inspectors found the actions identified by the provider following the last inspection had not been fully implemented as outlined within their action plan response. However, inspectors acknowledged the proposed timescale had not passed in relation to links with the community.

Inspectors acknowledged the changes in relation to the visitors policy, this facilitated residents receive visits without restrictions.

In relation to developing and maintaining links in the wider community plans were in place, yet, these had not impacted positively on residents. For example, on viewing some residents plans one resident had eight activities recorded since the previous inspection. Another resident had fourteen activities recorded none of these involved leaving the campus of the centre.

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 found the action identified by the provider following the last inspection had not been implemented. However, inspectors acknowledged the timeframe for this was the end of January 2018.

On viewing a sample of contracts in place, inspectors found the content included within residents agreements required significant improvement. Inspectors identified that content within the contract was not in accordance with residents' needs or rights.

In addition the fee charged to residents was not clearly outlined in terms of what was included in the fee and what residents were required to pay as additional fees.

Judgment:
Non Compliant - Moderate

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:

Inspectors found the three actions identified by the provider following the last inspection had not been implemented. However, inspectors acknowledged the timeframe for this was the end of April 2018.

Inspectors viewed a sample of five residents plans from a social care perspective the following were present: meaningful daily assessment, my life my way, my personal plan and silver birch nursing care plan. All of these documents focused on the social care needs of residents, however, none of them were linked to each other. Inspectors found the information included in these documents required significant improvements. For example, the section titled "my community inclusion" listed a number of items, one included going to bed. Inspectors asked staff members what this had to do with community inclusion, however, this information was not available. Overall inspectors found documents were present within resident's files, however, these were not impacting on residents lives. As various activities were identified with no evidence of progress or steps in relation to how residents would be assisted to achieve this aspect of their dreams or wishes.

Inspectors viewed the activity planner for residents, yet, the activities listed were prominently related to healthcare activities such as attending physiotherapy within the centre or their day care service.

Inspectors acknowledged the system had changed since the last inspection, to an assessment leading to one of the following plans being devised which included a reflex plan, sensory plan or exploratory plan. On viewing one plan all three plans were identified as a requirement, yet, the actual plan completed was exploratory, however, the contents was for a sensory plan. Inspectors identified this revised system was not impacting on residents lives positively as these were not completed correctly which resulted in staff members not being guided effectively. The system in place did not demonstrate how residents were involved or consulted in relation to the development of their plan nor were there effective arrangements in place to meet the assessed needs of residents from a social care perspective. 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.

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:

Inspectors found the action identified by the provider following the last inspection had not been implemented, however, inspectors acknowledged the timeframe for this was the end of June 2018.

Inspectors acknowledged some improvements in the area of cleanliness and maintenance but further improvements were required. On the day of inspection an environmental assessment was being completed by two external people.

Overall inspectors identified the centre remained comprised in terms of the lay out and design to meet residents' assessed needs. Residents continued to share bedrooms and there was a lack of sufficient storage for personal items.

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

The provider representative previously 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.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

Inspectors found the six actions identified by the provider following the last inspection had not been implemented. However, inspectors acknowledged the timeframe for these were the end of January and February 2018.

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

Inspectors were not assured there were effective arrangements in place in relation to fire safety and as a result on the day of inspection requested written assurances. Inspectors identified that fire drills completed did not demonstrate that the emergency plan in place was effective. For example, residents did not participate in fire drill. Staff members spoken with were not aware of the exit route to take in the event of a fire. Inspectors also identified that the emergency escape routes were not identified within the map of the centre displayed on the wall.

Inspectors observed fire doors were in place, however, how effective these were in relation to fire containment were unclear due to the significant gaps which existed between the joining of double doors. Inspectors found staff members were not guided adequately in relation to fire management to ensure all residents could effectively be evacuated.

From a staff training perspective 7% of staff members required training in the areas of fire safety. A sample of residents' PEEP's (personal emergency evacuation plans) had been developed since the previous inspection. The information contained within these documents was very limited. Inspectors were unable to ascertain if these were effective as residents had never participated in fire drills.

Inspectors acknowledged that the fire blankets had been serviced since the previous inspection.

Inspectors found the system in place in relation to the management of risks required improvement from an individual and locations perspective to ensure all risk were identified and were reviewed. Some risk assessments viewed were dated 2015 with no evidence of review, the individuals responsible for implementing the actions were no longer employed within the designated centre. Some actions were identified as urgent in January 2015 and another in January 2017 yet, no review of the risk had been completed since.

Arrangements to protect residents from healthcare associated infections were not effective. Inspectors observed staff members entering into a bedroom where a resident had a diagnosed healthcare infection; universal precautions were not used by staff members before or after leaving the bedroom. Inspectors also observed a yellow clinical waste bag, placed on a chair in the seating area of one of the units at 08:45hrs, on leaving the unit at 17:30hrs the bag remained on the floor beside the chair.

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

Theme:

Safe Services

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

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

Findings:

Inspectors found the two of the three actions identified by the provider following the last inspection had not been implemented. However, inspectors acknowledged the timeframe for these were the end of January and February 2018.

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. Inspectors identified no action had been taken following the previous inspection where sums of residents' money were unaccounted for. Inspectors were informed of a new system which was put in place in January, in relation to the recording of residents' finances. Inspectors requested to see evidence of this, however, the recording book was blank. Inspectors identified several potential incidents where financial abuse could have occurred and no action had been taken by the provider.

Training records identified 72% of staff members required training in the area of safeguarding residents and the prevention, detection and response to abuse. Inspectors spoke with five members of staff in relation to this and none of them were able to outline the different forms of abuse with the exception of one staff member. This staff member had not received training but identified they had researched this area of care provision themselves. No staff member spoken with was able to identify who the designated officer was in relation to allegations of abuse within the centre.

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 of abuse were not appropriately followed up on. Inspectors highlighted these to the person in charge and the representative of the provider during inspection.

Inspectors requested an update in relation to the staff members without Garda vetting, inspectors received confirmation post inspection that 35% of staff members were yet to have their applications completed.

Inspectors viewed some intimate plans of care for residents.

Inspectors viewed a resident's behaviour support plan which did not guide practice effectively. In addition, the plan did not demonstrate how the needs and wants of the resident were taken into consideration due to the language used within the document. For example, the document stated that the resident "must follow instruction in the

correct way" in another part of the plan it stated the resident felt unhappy when " people criticise the resident". Overall inspectors identified the plan did not take into account the resident's diagnosis of Autism and facilitate the resident to express their needs in a person-centred manner. Inspectors also viewed evidence of a multi disciplinary meeting conducted in 2014, where it was identified a smaller living environment would be more suitable for this resident. Inspectors requested an update in relation to this or if the resident had been reassessed, however, no evidence of this was available within the residents file. From viewing the plan it was also unclear that the all alternative measures were considered before restrictive procedures were implemented.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

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

Findings:

Inspectors found one of the two actions identified by the provider following the last inspection had not been implemented as outlined within the action plan response.

During this inspection, inspectors identified incidents which were required to be notified to the Chief Inspector within three working days of the occurrence. These included any allegation, suspected or confirmed, abuse of any resident.

Judgment:

Non Compliant - Major

Outcome 10. General Welfare and Development

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.

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 the action identified by the provider following the last inspection had not been implemented. Inspectors acknowledged the timeframe for this was the end of January 2018.

Inspectors, viewed a sample of residents files, however, these did not reflect opportunities for residents to engage in new experiences or social participation, education, training and employment in accordance with residents wishes. This was also identified during the previous three inspections.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Inspectors found the two actions identified by the provider following the last inspection had not been implemented. However, inspectors acknowledged the timeframe for one of the actions was the end of January 2018 in relation to the access to snacks outside of designated mealtimes.

Inspectors requested to view plans of care in place for specific healthcare conditions, however, these were not available. This was also identified during the previous inspection. Inspectors were therefore not assured that staff members were guided effectively and consistently in relation to the management of all healthcare conditions.

Inspectors viewed three other files which identified each resident was not for resuscitation. Inspectors requested to view the process which led to this decision. This was unclear, as no documentary evidence was available in relation to the discussion which was held with family members except for the fact that a discussion took place. No evidence was present that the resident themselves were involved in this significant decision making process. Inspectors were also informed that all three residents would be able to participate in such a discussion. Inspectors identified this did not ensure

residents were involved in decision about their care. Nor was it evident that residents' wishes were respected and documented in relation to their right to refuse the medical intervention of resuscitation.

Inspectors observed breakfast within one unit and found residents' needs were not adequately met nor was the experience of mealtimes homely. One resident was sitting at the table for 10 minutes before a staff member acknowledged the resident. During which time three staff members passed through the dining room. The inspector spoke with each of these individuals, however, two of these staff members were not working within the centre. One individual was a member of the activity staff and the other was a member from the physiotherapy department. The inspector identified the practice of staff members from other departments using the back door of the designated centre to gain access and walk through the resident's dining room was not contributing to a homely atmosphere for residents when eating. The third member of staff was from the catering department who did not know the names of the staff who had just walk through the dining room. Inspectors observed a fourth member of staff source breakfast for the resident and placed adopted utensils with the meal in front of the resident. A fifth staff member removed the adopted utensils and informed the fourth staff member to feed the resident. This commenced at 09:40hrs and from 10:00hrs to 10:28hrs the resident was left on their own in the dining room with the same cup of tea which was provided to the resident at 09:40hrs. The resident was subsequently taken to physiotherapy with the cup of tea, at which point the inspector checked the temperature of the tea which was cold. The inspector requested to view this resident's nutritional and hydration plan, this identified the resident required a minimal level of assistance, however, required to be supervised at meal times due to swallowing difficulties. The inspector identified assistance was not afforded to this resident in accordance with their assessed needs on in line with the resident's plan.

Inspectors viewed another plan, this identified that the resident's mother had deceased, from viewing this file the resident visited their mother regularly sometimes daily. However, no evidence of bereavement therapy or any interventions were identified to support the resident through this life changing event was evident. Inspectors identified this did not demonstrate that residents were supported in a manner which met their emotional and spiritual needs.

Judgment:

Non Compliant - Major

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:

Inspectors found the two actions identified by the provider following the last inspection had not been implemented.

The designated centre written policies and procedures which related to the administration, transcribing, storage, disposal and transfer of medicines was in draft format.

The maximum dosage for some PRN (a medicine only taken as the need arises) were not stated within the residents' administration records. No guidance documents were present in relation the administration of PRN medicine.

Inspectors observed that some medications were signed as administered before residents were administered the medication.

During a medication round the medication trolley was left unattended and unlocked.

Some medications were administered without the expiry date checked.

Inspectors asked some staff nurses what were the ten rights of medication, however, some nurses spoken with could only identify six.

The centre operated a system where the nurse administering medication wore a red plastic vest over their uniform, this was to ensure other staff did not disturb the nurse when administrating medication. However, inspectors observed other members of staff who required the attention of the nurse on three separate occasions in relation to care needs of other residents, therefore, staff members did not adhere to the system in place in relation to staff administering medications.

Capacity assessments had been completed for residents in relation to taking responsibility for their own medication, however, the criteria used to determine the outcome was unclear.

Judgment:

Non Compliant - Major

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 one of the two actions identified by the provider following the last inspection had not been implemented.

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 three inspections.

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:

Inspectors found four of the five actions identified by the provider following the last inspection had not been implemented. However, inspectors acknowledged the timeframe for this was the end of February 2018.

Inspectors identified while some progress had commenced in relation to the areas identified in the previous inspection, these were yet to enhance the quality of lives for residents. Significant improvements remained 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. This remained in place during this inspection.

Inspectors acknowledged a change within the system of oversight of the centre to ensure the safe, consistent and effective delivery of care in accordance with residents' needs as at implementation stage. Some audits had commenced and some of these had plans in place to address the findings, however, these were at infancy stage and had yet to bring about a positive impact.

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 some walk about within the centre since the previous inspection and had convened a team of people to address some of the findings.

The annual review was currently being complied for the centre.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Inspectors found two of the three actions identified by the provider following the last inspection had not been implemented.

Inspectors were informed on the day of inspection that the person in charge was not working on the day of inspection and a telephone call would be made to see who was

available. However, the person in charge came to the centre. The rota available within the designated centre did not reflect this information on the day of inspection.

From discussions with staff members inspectors identified staff members were not knowledgeable in relation the Act and the regulations and standards from a disabilities perspective. However, since the previous inspection ten members of staff had attended a workshop in relation to this and further works were planned.

Inspectors identified the staffing levels were not organised to meet the assessed needs of the residents. Inspectors were informed of changes to the levels since the previous inspections, however, this was not based on the assessed needs of residents. Inspectors acknowledged improvements in relation to the organisation of staff members during the night as staff members from this designated centre were no longer required to attend another designated centre.

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

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

Inspectors found one of the three actions identified by the provider following the last inspection had not been implemented. However, inspectors acknowledged the timeframe for this was the end of February 2018.

Inspectors viewed the Schedule 5 policies, and requested an update in relation to the ongoing work in relation to these. The medication management and risk management policies were scheduled to be completed by the end of January 2018 and the provision

of behavioural support and the use of cctv (closed circuit television) policy was scheduled be complete by the end of February 2018.

The directory of residents had been updated to include the name of the residents' general practitioner.

Inspectors identified improvements were required in relation to some Schedule 3 documents in relation to elements of assessments. Some plans were left blank in some areas and within other plans information not relevant to specific residents were contained within their file. For example, a chart to record pertaining to females was contained within a male resident's file. Inspectors found the language used within residents plans was not person centre and required review.

Inspectors also identified some Schedule 4 documents were not available within the designated centre on the day of inspection in to the residents guide, this was un available within one unit and in draft format within the second unit.

Judgment:

Non Compliant - Major

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003730
Date of Inspection:	23 & 24 January 2018
Date of response:	20 April 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:

A. 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.

B. Inspectors found the privacy and dignity of residents in relation to their living space was also compromised

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

1. 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:

A new privacy and dignity policy has been devised and implemented. Discussion and education provided to staff at nursing handover re same. Documentation of discussions are kept in the centre. 3 sessions of continence awareness planned for March 20th, April 4th and 11th.

Additional wardrobes have been obtained for the centre. Bedroom space has been enhanced for residents as numbers have decreased on Lisbri. Efforts are ongoing to address communal space options in the centre.

It has been documented in resident care plans if they wish to have their bedroom door open or closed during the day when they are resting.

Options to enhance living space are being explored through the environmental sub group. Bed numbers have been reduced. Furniture has been ordered by the CNM II to enhance opportunities for residents to watch televisions in their bedrooms. 3 Televisions have been ordered (2 have been delivered). This will ensure that each resident will have their own television in their bedroom. A request has gone to maintenance to erect these televisions.

There has been a concerted effort by staff to ensure that all visitors ring the doorbell prior to entering the centre. Improvements have been noted. However, an alternative door is now being sourced to address this matter comprehensively.

Multi-occupancy bedrooms are being reviewed to see if structural works can be carried out to reduce them to single occupancy

Proposed Timescale: 31/05/2018**Theme:** Individualised Supports and Care**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**

Consultation with residents in relation to the organisation of the centre was very limited.

2. 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:

The format of the residents focus meeting has changed, with a resident chairing the last 2 meetings with the support of staff. Minutes for this are recorded and are available to residents.

A comprehensive resident survey has concluded – findings are now being analysed by a specific sub group tasked with doing this. An action plan will be developed from this. 16 residents participated in this questionnaire survey.

2 residents have joined the project group, which meets fortnightly, chaired by the provider nominee to look at overall compliance with the regulations arising from the audit commissioned in November 2017.

The resident guide has been re written and is now available in an accessible format and is being made available. Residents were given the opportunity to review this. Any new information developed for residents will be reviewed by residents through the participation of residents in the project group and the resident focus meetings.

The schedule of provider visits (facilitated by a team) includes discussion with residents and family members (if in the centre) to ascertain their views on a regular basis. This is documented in the records of this.

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:

Inspectors observed routines during this inspection and also during the previous inspection which did not demonstrate consultation with residents due to the institutional type practices in place within the centre.

3. Action Required:

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. All efforts are being made to support the participation of residents in the running of the centre and to reduce the routine practices in the centre. Staff in the centre continue to remind other staff and visitors on the campus to ring the doorbell before entering Lisbri and to wait at reception before moving through the centre. However, management acknowledge this practice is not effective at times. Alternative options are now being explored to address this ongoing deficit. Using the dining room as a walk through has ceased. Access to the centre via the side door is being restricted to permanent staff in the centre only. This will include household staff, care assistants, nursing and catering. All other site and management personnel will not be able to access the centre this way.

- 2.The format of the residents focus meetings has changed. A resident has chaired the last 2 meetings with support from staff.
- 3.The model for Person centred plans has changed. O'Brien's 5 values is now being used to guide these plans. All residents in Lisbri have been involved in their PCP's, facilitated by their assigned key worker. The process has commenced in Elm.
- 4.A comprehensive resident survey has been completed as planned, the findings are currently being analysed, and there is a project sub group tasked with this work, chaired by the disability manager for the area, reporting to the project group (chaired by the provider nominee) which meets fortnightly. 2 residents now sit on this project group.
- 5.Storage has been increased for residents – additional wardrobes and lockers have been obtained.
- 6.Access to finances is being facilitated at centre level. Money for a number of residents who wish this is now held in the centre which residents can access when they wish. A SOP to support this locally is completed. A policy to support the SOP will be completed.
- 7.Training will be provided to staff on respectful and dignified communication with residents at all times

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:

Inspectors observed routines during this inspection and also during the previous inspection which were task orientated and practices which impacted on residents freedom to exercise choice and control over their daily life due to institutional type practice.

4. 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:

Efforts are being made to reduce the institutional type practices in the centre. Each resident has been assigned a key worker who is working with the resident and their family on their person centred plan. Some residents chose their own key worker. Opportunities for individualised activity are being created through this process.

Nursing staff working in these units no longer wear formal uniforms.

Consideration is being given to transport options, including the purchase of an 8-seater vehicle will allow for unplanned trips out of the centre for the residents on a daily basis.

A 0.5 WTE social worker is commencing 03/04/18.

Occupational therapy assessments have been completed on all residents in Lisbri .Some

of the residents have applied for a bus pass as part of developing links with the community.

All residents are encouraged to attend the unit focus groups to enable each individual to have a say in how the unit is run.

Training on culture and resident dignity for staff in everyday interactions with residents is being organised. Staff are being reminded of this on a daily basis by management.

Agency staff is being kept to a minimum.

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 resident could only access their money at specific time. 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:

Money is now held in the centre for residents who have requested this and is available at any time. Staff support residents to access this money as they require it.

Individualised ledgers are in place for each resident. A number of residents have identified as one of their goals in their person centred plans to learn more about managing their money. Residents will be encouraged and supported to open post office or bank accounts. They will be supported to do so by staff.

Process of reimbursing some residents is almost completed with arrangements being made by management to do this.

Proposed Timescale: 30/05/2018

Theme: Individualised Supports and Care

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

Some residents inadequate space to store and maintain his or her 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:

The service continues to analyse the use of space to best meet resident needs. Additional wardrobes and lockers have been obtained for residents who requested this.

Shelves have been put up in Elm for residents who requested this to facilitate storage of teddy bears. This was identified through the resident survey.

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:

Some complaints viewed did not identify what measures were required for improvement in response to a complaint.

7. 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:

Staff were supported by the provider nominee to identify required measures to resolve this complaint.

Complaints are being included as standing item on agenda for the Quality and Safety Committee for the centre and the centre staff meetings as part of revised structures underway.

The provider nominee has identified that staff require some training in documenting and following up complaints satisfactorily and will arrange this within the next number of weeks.

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:

Some complaints viewed remained unresolved with no evidence of any outcome document for the complaint.

8. 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:

Residents have an opportunity to raise issues with staff as they arise. A written record of complaints is kept in the centre. Staff are reminded by management how to best deal with complaints in line with the policy including follow up with complainants. An audit of complaints policy will be completed by the provider nominee by 31/03/18 as previously identified in previous action plans.

The provider nominee has identified that staff require some training in documenting and following up complaints satisfactorily and will arrange this within the next 4 weeks.

Proposed Timescale: 30/04/2018

Outcome 03: Family and personal relationships and links with the community

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.

9. 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:

All residents on Lisbri have had a person centred plan completed with their individual key worker. Links to the wider community have been clearly identified through this process for many residents and this is now being actioned by the key workers. Activities locally are being sourced with information being made available on the resident notice board.

A new daily activities board has been designed and is updated on a weekly basis in the ward office.

One resident has identified a bingo group in the local civic centre and is being supported by her staff and sister to do this.

One resident has started using local hairdresser.

Some residents have applied for bus passes and one resident has applied for her disability pass to be renewed.

Residents are also involved with their MDT meeting with their families where access to the community is discussed. A discussion has taken place at MDT meetings in relation to exploring other transport options with residents and families.

The person centred plan process has commenced on Elm, as have the MDT meetings.

An additional 0.5 WTE social worker has been sourced specifically for the centre and is due to commence week 26/03/18.

Proposed Timescale: 30/04/2018

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:

The agreements for the provision of services for residents required significant improvement in terms of the support, care and welfare and the services to be provided for residents while in the centre.

It was also unclear what residents were being charged for.

10. 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:

The contract of care is being redone to ensure that it is specific to the disability units and not the overall site. The agreement for the provision of services is being clarified, with services provided being detailed, including that no fees are charged for physiotherapy and occupational therapy. It is being reissued to service users.

Proposed Timescale: 30/04/2018

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 for all residents to reflect changes in need and circumstances, at a minimum on an annual basis.

11. 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:

Occupational therapy assessments are underway and have been completed for 13 of the residents in the centre.

Social work assessments have commenced – there is an additional 0.5 social worker being recruited for the centre commencing the week of 26/03/18.

MDT meetings have commenced for each resident and will be completed by 30/04/18.

Needs identified through this process will be addressed by the relevant healthcare professional.

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:

Effective arrangements to meet the assessed needs of each resident from a social care perspective were not evident.

12. 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:

Assessed needs will be met by the relevant healthcare professional as described above.

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:

The system in place did not demonstrate how residents or their representatives, in accordance with the resident's wishes were involved or consulted in relation to the development or review of their plans.

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:

Multidisciplinary team reviews currently taking place with each resident and their families. Evidence is available to support their involvement in this process. By the 22/03/18, 11 residents will have had a MDT review. A number of residents to date did not wish a family member to be present at the MDT meeting. Residents are supported to attend these meetings by their key worker. Completion date for all resident MDT's is

30/04/18.

Proposed Timescale: 30/04/2018

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:

Improvements were required in relation to the premises state of repair.

14. 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:

External contractor has cleaned the centre inside and externally.

Schedule is in place to clean the courtyard area weekly.

Lisbri will be painted following the exploration of options in the multi-occupancy bedrooms to see if structural works can be carried out to reduce them to single occupancy.

External courtyards are being re-surfaced

Proposed Timescale: 31/05/2018

Theme: Effective Services

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:

This action plan response did not satisfactorily address the identified failings

Proposed Timescale:

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 meet within the centre.

16. 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:

Wheelchairs previously stored in the dining area have been removed, increasing the space available to residents in this area.

The number of residents has reduced in Lisbri overall to 13 long stay residents and 4 maximum respite residents. There is now only 1 three bed room for long stay residents.

Review of the environment has taken place to ascertain what works are required and to determine the use of communal space for residents. An environmental sub group has been established to work on this.

Proposed Timescale: 30/04/2018

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

17. 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 assessments have all been reviewed for the centre by the Quality and Safety Advisor for CHO 7 with nursing management for the centre.

2.Risk assessment training took place, attended by the CNM II, and 2 x CNM I

3.Risk management policy is completed and operational. Training on this will be scheduled by the education officer for the site.

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

A. The management of clinical waste required improvement.

B. Infection prevention and control measures were not appropriately implemented.

18. 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:

Additional infection control education sessions on the management of clinical waste have been provided to the staff on the unit by the Clinical Nurse Specialist in Infection Prevention and Control.

This area will be included in the 6 monthly environmental audits carried out by the CNS in IPCC and the Household Supervisor.

There is a comprehensive IPCC policy that is reviewed by the Consultant in Microbiology on a continuous basis and updated accordingly.

On the day of inspection it was a pressure relieving mattress that was put into a clinical waste bag whilst it was waiting collection from the company.

Both CNS in IPCC and Household supervisor have advised staff that this is not appropriate practice. The company who supply mattresses have also been asked to supply a specific bag for removal of these mattresses in the future to eliminate this from reoccurring.

Proposed Timescale: 24/01/2018

Theme: Effective Services

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

A. Fire safety management required improvement as fire drills at suitable intervals were not conducted with residents.

B. Some staff members were not aware of the procedure to be followed in the case of fire.

19. 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:

Residents are involved in monthly fire drills and evidence is available in the centre to support this. A night fire drill is planned for Lisbri for 23/03/18 and for Elm on 28/09/18. All residents now have a PEEP.

Monthly fire drills are being recorded with additional information. Further training has been provided by the fire officer to staff. A further session took place on 21/03/18. All staff (with the exception of one staff member who is currently on nights) will have attended fire training. Fire is included on the provider visits – staff are asked questions and documentation is reviewed by the team undertaking these visits.

Proposed Timescale: 21/03/2018

Theme: Effective Services

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

Adequate arrangements for containing fires within the centre did not exist.

20. Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

Maintenance Department are reviewing all fire door assembly maintenance works identified by staff This includes the installation of intumescent and smoke seals on doors and frames, replacing screws to hinges, repairing self-closing devices and adjusting doors to ensure they close fully with receivers engaging.

The issue of gaps between double fire door leaves has been noted and a strategy to tackle this issue is being prepared. The maximum acceptable gap between the double doors is 4mm. To reduce the existing gaps, the doors have to be removed and hinges packed or a hardwood panel fixed to the edge of the door(s). This cannot be readily carried out on site for health and safety reasons and in some instances can be a timely task. The location of double doors containing gaps greater than 4mm are being identified. Maintenance and the fire officer are working on a process and timeline to complete said works. These works will be completed by 13/04/18.

A schedule of fire checks, including weekly tests and regular servicing of equipment, including emergency lighting is done by Masterfire. Records are held in the centre.

Proposed Timescale: 13/04/2018

Theme: Effective Services

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

Adequate arrangements for evacuating all residents in the designated centre and

bringing them to safe locations were not evident.

21. 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:

Monthly fire drills now include residents. Evidence is available in the centre to demonstrate their involvement. An Additional Information sheet has been developed and is attached to the monthly fire drill section of the register. It documents how many staff were available for the evacuation, times they arrived to the unit and the time taken to evacuate residents. Issues or concerns will then be identified and actioned appropriately by the nurse in charge.

Proposed Timescale: 21/02/2018

Theme: Effective Services

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

Adequate precautions were not take against the risk of fire.

22. Action Required:

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

A schedule of fire checks, including weekly tests and regular servicing of equipment, including emergency lighting is done by Masterfire. Records are held in the centre.

Monthly fire drills are on going, which now include resident participation. These are documented in the fire record in the centre.

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

An effective fire safety management system was not in place within the centre.

23. 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:

The evacuation strategy for the building is progressive horizontal evacuation and so staff are trained to evacuate occupants from the compartment containing the fire, into the adjoining compartment and further along the building. The exits from bedrooms are not considered required for escape as the appropriate number and location of final exits are considered to be provided.

Additional fire training has taken place with staff in the centre. This included fire evacuation drills and was facilitated by Masterfire at the end of January. A further fire training session is scheduled for 21/03/18. Following this all staff should have attended fire training.

Floor plans are being revised to include the numbering of all rooms and clear identification of fire exits

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:

The procedure displayed to be followed in the event of fire did not identify the location of the emergency exits.

24. Action Required:

Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

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

The rooms in the centre are being numbered by Masterfire as instructed by the fire officer. Once this is completed the floor plans will be redone with exit signs clearly marked.

Proposed Timescale: 30/04/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

A. Behaviour support plan viewed was not guiding practice in a person-centered manner.

B. Every effort to identify and alleviate the cause of residents' behaviour was not evident before restrictive procedures were used.

25. Action Required:

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

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

This care plan has been reviewed by the behavioural specialist for the centre. The care plan has been renewed and drawn up in consultation with this resident. The learning from this will be considered in reviewing all behaviour support plans.

Proposed Timescale: 30/04/2018**Theme:** Safe Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

72% of staff members required training in the area of safeguarding residents and the prevention, detection and response to abuse.

26. Action Required:

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

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

Further training dates for safeguarding awareness in addition to Train the trainer training has been arranged with the Safeguarding Team CHO 7 for 06/04/18.

Proposed Timescale: 30/04/2018**Theme:** Safe Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Some allegation or suspicion of abuse were not investigated nor was any appropriate action taken.

27. 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:

A review of finances has taken place by the Grade VIII hospital manager. 3 residents were identified as requiring monies reimbursed which has been actioned. A further review of resident historical accounts is planned for April 5th 2018 which will be

conducted by a member of social care finance team CHO 7. A local policy is almost completed in the centre which will safeguard against financial abuse for residents.

Incidents are being reviewed on a weekly basis in the centre to ensure all potential safeguarding issues are being highlighted and managed appropriately.

Proposed Timescale: 30/04/2018

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 as identified within the report.

28. 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:

Safeguarding awareness training is being arranged with the Safeguarding Team CHO 7. A final session is now planned which will see an increase in training rates. This has been scheduled for 06/04/18.

Staff are being questioned regularly by management on safeguarding and their awareness of same. A final date of 31/03/18 has been set for all staff to read the safeguarding policy.

A review of resident finances has taken place for 2017 and arrangements are in place to reimburse monies owed. The provider nominee made decision to retrospectively review finances which is being done by a member of the CHO 7 finance team on 05/04/18.

Local processes to support resident monies being held in the centre are almost completed.

Proposed Timescale: 30/04/2018

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 three working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

29. 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:

This was retrospectively submitted. Incidents are being reviewed weekly by the provider nominee with nursing management to determine if it is considered a notifiable event.

Proposed Timescale: 30/04/2018

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.

30. 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:

This is being explored in the context of the Person centred plan process and is progressing for each resident, facilitated by their key worker and the MDT. The rehabilitation guidance service for CHO 7 have also been asked to assist with this process.

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:

Healthcare plans were not developed for some healthcare conditions.

31. 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:

Every resident is reviewed by a Multidisciplinary Team every 3 months which includes medical and nursing staff. The individual plans of care updated if any changes are prescribed. Each resident is reviewed by a medical officer if there are any changes in an individual's condition and care plans reviewed and amended accordingly.

Proposed Timescale: 30/04/2018

Theme: Health and Development

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

Residents were not provided with support in terms emotional and spiritual needs following significant life events.

32. Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

Supports will be provided to residents at times of illness or at the end of their lives if identified by the resident or a member of the team.

Bereavement counselling is currently offered and will continue to be offered to any residents in the event of the death or critical illness of a loved one.

Proposed Timescale: 31/03/2018

Theme: Health and Development

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

The process was unclear in relation to the decision making framework for do not resuscitate orders and collaboration with residents was not documented within their files in relation to the decision made.

33. Action Required:

Under Regulation 06 (2) (c) you are required to: Respect and document each resident's right to refuse treatment and bring the matter to the attention of the resident's medical practitioner.

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

By end of April all charts will have a purple form documenting discussions and decisions made as well as the rationale for reaching the decision. These will be based on either discussions that have already taken place or else on new discussions where older documentation may be incomplete or otherwise sub optimal. This will ensure that all discussions and the outcome of such are documented. The senior medical officer and a senior member of the unit nursing staff normally facilitate these discussions.

Proposed Timescale: 30/04/2018

Theme: Health and Development

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

Assistance with eating or drinking, in an appropriate manner in accordance with the assessed needs of residents was not provided as outlined within the report.

34. Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

Lisbri unit has a maximum capacity of 17 residents (including 4 respites). From 08.00-17.30 there are 7 staff on duty, 4 nurses and 3 care assistants. From 17.30-20.00 there are 6 staff on duty, 3 nurses and 3 care assistants and from 20.00-08.00 there are 3 staff on duty, 2 nurses and 1 care assistant.

Elm unit has a maximum capacity of 10 residents (including 2 respites). From 08.00-17.30 there are 5 staff on duty, 3 nurses and 2 care assistants. From 17.30-20.00 there are 3 staff on duty, 2 nurses and 1 care assistant and from 20.00-08.00 there are 2 nurses on duty.

There are dedicated catering assistants on duty from 07.30-19.30 on both units. Staff will be familiar with needs of residents and assistance provided accordingly.

An audit of meals and mealtimes is required to ensure arrangements and supervision at mealtimes is adequate and to facilitate a homely and pleasant atmosphere for residents.

Increased supervision will of mealtimes experience will be put in place.

Proposed Timescale: 30/04/2018

Theme: Health and Development

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

Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

35. 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:

Residents have access to a snack / buffet bar during the day where snacks, hot and cold drinks are available.

Proposed Timescale: 31/01/2018

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:

Appropriate and suitable practices relating to medication management was not evident in relation to the following areas;

The maximum dosage for some PRN was not stated within the resident's administration records.

No guidance documents present in relation the administration of PRN medicine.

Some medications were signed as administered before residents were administered the medication.

Some medications were administered without the expiry date checked.

Some staff nurses what were the ten rights of medication movement.

Staff were disturbed during medication administration rounds.

36. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

New medication kardexes are currently being piloted on 2 units on campus, these kardexes will address many of the concerns raised.

An audit tool has been developed that will be put into practice once the pilot has concluded and the kardexes are in use.

Staff who are administering medications wear a red bib to inform residents and other staff that they are not to be disturbed while on the medication round however some of the residents have ABI's and do not understand. All residents are educated about the relevance of the red bib; this will be reinforced on a continuous basis.

Training dates for local policy training are being scheduled by the education officer the site. The Policy is available on the units presently.

Proposed Timescale: 30/04/2018

Theme: Health and Development

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

The medication trolley was left unlocked and unattended during an observed medication round.

37. 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:

The staff member in question has been spoken to by nursing management, has written reflective piece on this and is being asked to complete the Hseland module again. Supervision of medication rounds has also taken place.

All staff members on both units have been asked to complete medication management on HSELand and will repeat every 2 years thereafter.

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:

The outcome of the capacity assessments was unclear in relation to the criteria used to determine the outcome.

38. 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:

The Senior Medical Officer is very familiar with all residents and sees them on an almost daily basis. There is a wide range of ability among the residents which varies from those in a very low level neurological state to those whose capacity and cognitive function is fully intact. Capacity is task specific. A small number required an assessment which involved asking many questions and presenting them with various case scenarios to evaluate their ability to understand the process involved and to establish whether they would be likely to reliably and consistently manage their medication. Because all of our residents bar one informed the medical officer early in the discussions with them that they did not wish to manage their own medication there was no requirement to proceed to full capacity assessment of their ability to manage this task.

One resident said he wanted to think about it when approached by the medical officer initially but a few days later he told the medical officer that he had decided against managing his own medicines.

The document placed in the back of the charts does clearly state whether each resident, in the opinion of the medical officer, has the capacity to manage their

medication or not. None of the residents wished to manage their own medication.

Proposed Timescale: 28/02/2018

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:

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

39. 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:

The Statement of purpose is currently being revised by the provider nominee to reflect the new format set out by HIQA.

Proposed Timescale: 31/03/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

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.

40. 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:

The CNM II will take over as person in Charge effective from April 23rd 2018. The person in Charge will attend all relevant committees after this to ensure governance arrangements are strengthened across the service.

Proposed Timescale: 23/04/2018

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 occurring within the centre.

41. 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:

Training on person development plans is taking place for the CNM II and 2 x CNM I's during April and May. This will be rolled out for all staff following this.

A training needs analysis has been completed by the education officer for the service and a Training matrix will be completed following the implementation of the PDP's following the last training session on the 4th May . This will ensure recording and oversight of the training needs of all staff to include mandatory and professional development. All staff have completed person centred planning training and are now in the process of completing modules on both Medication Management and Handling Complaints on HSELand. To date mandatory training for both units is as follows: Lisbri Unit- CPR =75%, Manual Handling =100%, MAPA = 90% , Safeguarding = 70%. Fire =70% (with 30% of staff just out of date and due for renewal at next session dated April 24th)

Elm Unit – CPR =93%, Manual Handling = 100%, MAPA = 100%, Safeguarding = 80%, Fire =80%.

The Education Officer has completed a module on HSELand in 'Evaluating and Sustaining Organizational Learning' and will develop an evaluation tool for staff on the appropriateness of implemented training/education, the effect on the staffs performance and on the organisation they work in.

Proposed Timescale: 15/05/2018

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.

42. 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:

The management structure has been revised. The CNM II will assume the Person in Charge role from 26/03/18. A dedicated staff member from nursing administration will be on site weekly to support and monitor the service.

The governance structure framework is also in the process of being revised, with new processes underway. This includes Quality & Patient Safety Committee and provider management meetings and unit meetings. The CNM II will attend these meetings from April onwards.

Proposed Timescale: 30/04/2018

Theme: Leadership, Governance and Management

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

The management system in place in the designated centre did not ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored

43. 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 structure and format of the monthly provider management meetings, QPS meetings is being revised to ensure a more robust governance structure framework.

A schedule of regular provider visits is in place and these are taking place. These visits are being written up and are available in the centre.

Proposed Timescale: 30/04/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staff were not aware of the rota of the person in charge and this was not reflected within the rota displayed on the day of inspection.

44. 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:

The Person in charge was not working on the day of the inspection, but came in voluntarily to facilitate the inspection.

The rota in the centre reflects the staff on duty and is amended to reflect changes that occur at short notice.

Proposed Timescale: 31/03/2018

Theme: Responsive Workforce

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

Staffing was not organised to meet the assessed needs of the residents.

45. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

The skillmix in the centre has been reviewed to better reflect the needs of the residents. Additional social care qualified staff are being recruited to better meet residents social care needs. One RNID nurse and HCA with a social care qualification have commenced in the unit. The process for recruitment of a social care team leader has commenced. Additional occupational therapy and social work supports are being made available in the centre.

Lisbri unit has a maximum capacity of 17 residents (including 4 respites). From 08.00-17.30 there are 7 staff on duty, 4 nurses and 3 care assistants. From 17.30-20.00 there are 6 staff on duty, 3 nurses and 3 care assistants and from 20.00-08.00 there are 3 staff on duty, 2 nurses and 1 care assistant.

Elm unit has a maximum capacity of 10 residents (including 2 respites). From 08.00-17.30 there are 5 staff on duty, 3 nurses and 2 care assistants. From 17.30-20.00 there are 3 staff on duty, 2 nurses and 1 care assistant and from 20.00-08.00 there are 2 nurses on duty.

The Education officer has commenced a database inclusive of all staff members indicating all individual training/courses completed. It will assist with achieving the appropriate skill mix requirements for each unit and identify areas of education required to meet national standards.

Proposed Timescale: 30/06/2018

Theme: Responsive Workforce

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

Some staff members were not knowledgeable in relation to the Act and any regulations and standards made under it.

46. 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:

Further training days in relation to the Act are being held on 23rd and 28th March facilitated by an external organisation.

Staff are including the discussion of a regulation in the daily handover.

Proposed Timescale: 30/04/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

All of the Schedule 5 policies as outlined within the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were not completed or available to staff members.

47. 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:

Work is on going in relation to policies and procedures set out in Schedule 5. The behavioural support policy which is being updated to include safeguarding policy. The most recent policy completed is the CCTV policy. A further review of polices against the schedule is required.

Proposed Timescale: 30/04/2018

Theme: Use of Information

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:

Improvements were required in the maintenance of the records in relation to each resident as specified in Schedule 3.

48. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

Schedule 3 records are currently under review to ensure all are available in the centre.

Proposed Timescale: 30/04/2018

Theme: Use of Information

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

Improvements were required in the maintenance of the Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

49. Action Required:

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:

Schedule 4 records are currently under review to ensure all are available in the centre. However, since this inspection, the residents guide for Lisbri has been reviewed and is available in the centre. The residents guide for Elm is almost completed. The statement of purpose is under review in line with guidelines set out by HIQA February 2018.

Proposed Timescale: 30/04/2018

