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<th>Stewarts Adults Services Palmerstown Designated Centre 3</th>
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<tr>
<td><strong>Centre ID:</strong></td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Thomas Hogan</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Ciara McShane</td>
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About monitoring of compliance

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal 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: 07 December 2017 08:20  
To: 07 December 2017 17:10  
From: 08 December 2017 08:10  
To: 08 December 2017 12:15

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

| Outcome 04: Admissions and Contract for the Provision of Services |  
| Outcome 06: Safe and suitable premises |  
| Outcome 07: Health and Safety and Risk Management |  
| Outcome 08: Safeguarding and Safety |  
| Outcome 11. Healthcare Needs |  
| Outcome 12. Medication Management |  
| Outcome 14: Governance and Management |  
| Outcome 17: Workforce |

**Summary of findings from this inspection**

Background to the inspection:

This was an unannounced inspection to assess the designated centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was conducted as part of the provider's application to renew the registration of this designated centre. It was the Health Information and Quality Authority's (HIQA) fourth inspection of this designated centre and it was completed over two days by two inspectors. At the time of the last inspection (27 July 2017) inspectors found all eight outcomes inspected against to be in major non-compliance with the Regulations. As a result of the concerns found at the time of that inspection, notices of proposal to cancel the registration and refuse the renewal of registration of the designated centre were issued. Representation was submitted to HIQA by the registered provider following the issuing of the notices of proposal and the assurances outlined in this document formed a core element of this inspection process.

Description of the service:

The registered provider had produced a statement of purpose which outlined the services provided within this designated centre. The centre was based in a large campus based setting in Dublin and was comprised of five detached buildings which
provided residential services to 38 persons with disabilities at the time of inspection.

How we gathered our evidence:
Inspectors met with 28 of the residents availing of the services of the centre and spoke in detail with three residents. Inspector also spoke with 14 staff members, persons in charge, the programme manager, and the director of care. Various sources of documentation, which included the statement of purpose, residents' files, centre self-monitoring records, policies and procedures, risk assessments etc., were reviewed as part of this inspection. Additionally, in assessing the quality of care and support provided to residents, inspectors spent time observing staff engagement and interactions with residents. Also a full walkthrough of the centre was completed by the inspectors.

Overall judgment of our findings:
Eight outcomes were inspected against as part of this inspection and overall the inspectors observed a very high level of regulatory non-compliance. All eight outcomes were found to be in major non-compliance with the Regulations. 19 of the 28 actions which arose from the previous inspection were found not to have been satisfactorily implemented.

Overall, inspectors found that the service provided in the designated centre was not safe and had failed to protect residents from abuse. Concerns were identified relating to the healthcare provided to residents and specifically supports in place to ensure sufficient fluid and nutritional intake by residents. Further concerns related to the overall governance and management of the centre, fire protection, health and safety and risk management, the use of institutionalised practices in the centre, medication management, and inappropriate staffing numbers to meet the assessed need of residents.

These findings, along with further details, can be found in the body of the 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 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 that since the time of the last inspection, all three actions relating to Admissions and Contract for the Provision of Services had not been satisfactorily implemented. There remained an inappropriate mix of residents in the designated centre which was not based on assessed needs and age.

A review of the files of residents who were availing of the services of the designated centre at the time of inspection found that of 32 records viewed, nine files contained full written agreements. A further 19 files contained only scanned images of one page of the written agreement. Arrangements which were agreed in this document were not available to inspectors at the time of inspection. A further four residents were found not to have written agreements available on file. Inspectors found that written contracts for the provision of services which were in place were not in line with regulatory requirements. Of the 32 files reviewed by inspectors, 23 were found to have no details available in individual resident files with regards to the fees being charged for services provided.

There were no admissions or discharges from the designated centre since the time of the last inspection.

**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 that the design and layout of two units of the designated centre was not suitable for the stated purpose and was not meeting the residents' individual and collective needs in a comfortable and homely way. Three of the four actions arising from the last inspection of the designated centre relating to safe and suitable premises were found not to have been satisfactorily implemented.

Overall, inspectors found that there were remedial works required to repair damaged plasterboards and repaint chipped paint and damaged walls throughout three of the five units of the designated centre.

In one unit inspectors observed household waste discarded in the rear garden along with obsolete garden furniture which were found to be a risk to residents, staff and visitors. While arrangements were in place for the disposal of general and clinical waste, these were found not to be effective with regards general or household waste. Other findings of concern in this unit included mould visible in a shower room, cobwebs in a bathroom area, restricted area for movement in a shower room, and the lack of appropriate storage space for equipment such as hoists.

In two other units of the designated centre, inspectors found extensive stains and markings on floors and tiles, broken furniture and damage to door frames. In one of these units, inspectors found a malodour throughout the ground floor of the building.

**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 that the health and safety of residents was not maintained, promoted and protected in the designated centre. Significant concerns identified at the time of the last inspection were found to not to have been satisfactorily addressed. In addition, further significant concerns relating to the areas of management of risk, incident and accident management, and the adequate precautions in the risk of fire were identified at the time of this inspection.

Four of the five actions issued at the last inspection were found not to have been satisfactorily implemented.

The clear and substantial absence of arrangements for the identification, investigation and learning from serious incidents which resulted in poor outcomes for residents and exposing residents to serious risk of injury and harm which had been identified at the time of the last inspection had not been satisfactorily addressed. Inspectors found that in the time since the last inspection six incidents which had occurred in the designated centre were not appropriately followed up on.

Serious concerns were identified by inspectors in the area of fire protection and for the safe evacuation of residents in the event of a fire. In one unit of the designated centre it was found that a fire drill which reflected true staffing and resident ratios had not been completed in at least a three year period. While fire drills had been completed in this area in the intervening time period, these had either a reduced resident number present or an increased staffing number present.

63.5 per cent of staff members employed in the designated centre were found not to have participated in a fire drill.

Staff knowledge of actions to take in the event of a fire was found to be of concern to inspectors with uncertainty as to the location of assembly points, limited awareness of the specific requirements of residents, and absence of direction on how to use assistive emergency equipment. In one unit, inspectors found that no staff member on duty at the time of inspection had competed a fire drill in that area. In addition, a shift leader for one unit stated that they were not confident that all residents could be evacuated safely in the event of a fire.

Fire doors were found to be wedged opened in three of the five units of the designated centre at the time of inspection. Emergency lighting was found not to be in place in five areas of the designated centre all of which contained emergency. This was an action from the previous inspection. Smoke detectors were found not to be in place in an area of one unit which contained a tumble dryer and washing machine.

In one unit of the designated centre, a review of personal emergency evacuation plans (PEEP) documents found that all five individuals living in the centre required one-to-one support in the event of a fire with constant supervision. However, a review of staff duty rosters found that only two staff were employed in the centre at night time and confirmation was not available of the number of staff that were available to respond from other areas of the campus when required.
Risk assessments which were reviewed by inspectors in one unit of the designated centre were found not to have been appropriately completed, and were not clear on the meaning of hazard identification. In one case a completed risk assessment did not list any identified risk or hazard. Where risks were identified, it was found that additional control measures were not listed to reduce the likelihood and/or impact of the risk.

A review of staff training records found that 15.9 per cent of staff members had not completed fire training in line with the organisation's requirement.

**Judgment:**
Non Compliant - Major

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**Outcome 08: Safeguarding and Safety**

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

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**Theme:**
Safe Services

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

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

**Findings:**

Inspectors found that residents had not been protected against abuse in the designated centre. There remained concerns regarding the lack of knowledge and recognition by staff members of what constituted abuse and the actions required to be taken in the event of witnessing or suspecting abuse. Serious concerns remained regarding the lack of appropriate response to safeguarding incidents in the designated centre. Inspectors found that all incidents of a safeguarding which had occurred in the centre since the time of the last inspection had not been responded to in accordance with the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (Health Service Executive, 2014).

A review of incident and accident reports relating to all areas of the designated centre found that six incidents of abuse had not been appropriately followed up on in line with the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (Health Service Executive, 2014). Three of these incidents related to peer to peer abuse, while the remaining three incidents related to unexplained injuries sustained by residents.
Inspectors spoke with five staff members about what constituted abuse and the appropriate actions to take in the event of witnessing or suspecting abuse of a resident. One staff member demonstrated appropriate knowledge of these areas. One staff member spoken with could identify only one type of abuse and could not identify the designated safeguarding officer. Overall, inspectors found the knowledge of the types of abuse and the actions to take in the event of suspecting or witnessing abuse of those spoken with to be wholly unsatisfactory.

A review of staff training records found that only 4.8 per cent of staff members employed in the designated centre had completed training in 'safeguarding vulnerable persons awareness programme'. When clarification was sought, a training officer confirmed that this programme was deemed a mandatory training requirement for all staff.

One resident spoken with who was availing of the services of the designated centre outlined to inspectors that they did not feel safe in their current living arrangements and alleged that they had been assaulted in the recent past by another resident. They stated that they did not want to continue residing in the designated centre and instead wished to live with individuals of their choice.

In two separate units of the designated centre inspectors observed residents using toilet facilities with doors opened and privacy and dignity not maintained. In both instances, inspectors observed staff members walking past the toilet areas with the doors opened and not take action to address the compromised privacy and dignity of the residents involved.

Inspectors spoke with a staff nurse/shift leader of one unit of the designated centre regarding behaviour supports in place for residents. The staff nurse stated they were unsure how many residents in their care had a behaviour support plans in place. When asked how many behaviour support plans they had read, the staff nurse confirmed that they had not read any of the plans in place. When asked about safeguarding plans, the staff nurse thought that all ten residents had a plan in place but confirmed that they had not read any of these plans.

A review of safeguarding plans by inspectors in one unit of the designated centre found that no such plans were in place despite a number of incidents having taken place which met the definition of abuse as outlined by the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (Health Service Executive, 2014).

**Judgment:**
Non Compliant - Major

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

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

Findings:
Inspectors found that residents' healthcare needs were not appropriately or safely met in the designated centre on the day of inspection.

While staff members spoken with demonstrated comprehensive knowledge of the healthcare needs of residents, inspectors identified serious concerns relating to nutritional and fluid intake of residents, healthcare plans in place to guide practice, and appropriate follow up by allied healthcare professionals.

A review of daily nutritional and fluid intake records of four residents was completed by inspectors. In the case of one resident, who was supported with fluid and dietary needs through the use of a transgastric tube, records reviewed stated that the resident had not received the recommended 1600mls of fluid or nutritional feed on at least four days of the period reviewed by the inspectors. On one of these days records stated that only 30mls were administered via the resident's transgastric tube in a 24 hour period. In the cases of the three other residents who had records reviewed by inspectors, it was found that total daily fluid and dietary intake was not satisfactory. In the case of one resident, a total daily intake of a small yoghurt and an average sized portion of breakfast cereal in the morning and had shepherds pie with veg and an glass of orange squash in the afternoon had been recorded.

In the case of two residents for whom reviews of hydration and nutritional intake took place, inspectors found that dietetic inputs had not taken place in nine months in one case despite a recommendation of three monthly reviews and in eight months despite a two monthly review recommendation.

Immediate written assurances were sought from the service provider regarding concerns identified with hydration and nutritional intake of residents in the designated centre.

A review of healthcare plans in one unit of the designated centre found that six healthcare issues identified by the staff nurse spoken with by inspectors did not have corresponding healthcare plans in place. In the case of one resident, a healthcare plan was found not to be in place for epilepsy. In the case of three healthcare plans which were in place in the designated centre, these were found not to sufficiently guide staff practice. In addition, inspectors found that plans were not reviewed on at least an annual basis with multidisciplinary involvement. A healthcare plan in place for one resident with epilepsy did not outline how the individual presented when experiencing seizure activity or how staff were to manage that healthcare need.

Meal time experiences were observed by inspectors in three units of the designated centre. In one area inspectors found this to be an unpleasant experience for residents and institutionalised practices were observed in this period. Two sittings of lunch were
observed to take place with one group of residents at each sitting. Residents were observed sitting 21 minutes at the dining room tables waiting for the meal to be served and staff were observed not to have sat with residents during this time or during the meal. Some residents were observed to become restless in this time period. One resident who had waited for the 21 minute period along with other residents was observed to have been asked to leave the dining room area when the meals were served as they had been allocated to the second sitting. Staff were observed not to have explained to residents what was being served for lunch and when one staff member was asked by the inspector, they were unable to confirm what the meal consisted of.

In another area inspectors observed lunchtime which was to be a relaxed affair with sufficient staff to support residents with their meals. Residents also had options available to them regarding their lunchtime meal. However, in a third unit inspectors observed breakfast which was reflective of institutional type practices. For example, inspectors observed a staff nurse on duty prepare a large bowl of porridge for the residents. When asked by the inspector were the residents given an option other than porridge they stated they had not been. One resident communicated with a care staff that they did not want porridge, the care staff made other offerings to the resident which they were receptive of. When spoken with by inspectors, the director of care confirmed that institutionalised practices remained in place in some areas of the designated centre and particularly around mealtime experiences of residents.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Inspectors found that medication practices in the designated centre did not ensure that residents were appropriately protected.

An appropriate system for the review and monitoring of safe medication management practices was found not to be in place in the designated centre. A review of medication administration records by inspectors found seven occasions where medications were prescribed but not administered to two residents. No incident reports were found to have been completed to reflect these medication errors.

In one unit of the designated centre a staff nurse was observed preparing medications
for administration and leaving these unattended while addressed to another matter. Two medications were observed to have been crushed while these were not prescribed to have been administered in this manner.

A staff nurse in one unit of the designated centre confirmed that no risk assessments or capacity assessments had been completed regarding the self administration of medication by residents.

Judgment:
Non Compliant - Major

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 that effective management systems were not in place in the designated centre to support and promote the delivery of safe, quality care to residents. It was found that the provider had continued to fail to provide a safe and reliable service in which residents' needs were appropriately met and protected from abuse. In addition, it was found that there was inadequate monitoring of the service taking place.

Six unannounced six monthly visits were found to have been completed within the designated centre across all five units since the time of the last inspection. Inspectors found that the six monthly unannounced visit reports were not completed to a satisfactory standard with four visits not having included any consultation with relatives or representatives of residents, two visits not completing appropriate review of notifiable incidents, at least one visit not competing a review of complaints made, and overall an absence of accurate findings. The reports of the unannounced six monthly visits completed which made available to inspectors failed to identify the issues of concern found during inspection.

Since the previous inspection the provider had made significant changes to the senior and middle management teams. Two programme managers had been appointed in addition to the appointment of a director of nursing. Four persons in charge had also
been recently appointed as part of a reconfiguration of the designated centre. The provider, at the time of the inspection, was also in the process of recruiting social care workers. However, at the time of inspection it was not evident that this was having a positive impact on the quality and safety of care for residents. As identified in other areas of this report, significant issues were identified in the provision of healthcare, in the safe medication management practices, health and safety and risk management, and safeguarding and safety which resulted in increased risk for residents availing of the services of this designated centre. This was compounded in some cases by a failure of the provider to provide adequate levels of staff, and to identify these practice issues through their own supervision arrangements.

**Judgment:**
Non Compliant - Major

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**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:**
The inspectors found sufficient staffing levels were not consistently provided in accordance with the stated requirements. In addition, the inspectors found the stated staffing levels in one unit were not safely meeting the needs of residents. Nursing care was not always provided as per the needs of the residents. There was an over reliance on agency staff to fill vacancies in the designated centre.

The inspectors reviewed rosters for four units and found staffing levels were frequently below the stated required levels. For example, in one unit, for a nine day period reviewed, staffing levels were below requirement on five of these days. On the day of inspection, staff members spoken with were unable to confirm what staff were assigned to work in the area the following day as duty rosters had not been finalised. In addition to this, inspectors found that continuity of care was a serious concern in the centre give the reliance on agency staff and the limited knowledge the staff team had of the residents for whom they were supporting.

A staff member spoken with in one area of the designated centre stated that the service provided was not safe given the number of staff employed and the reliance on agencies...
to supplement these levels.

Actual rosters reviewed were poorly maintained. Times staff were on duty and complete names for staff were not consistently recorded in these rosters.

Inspectors were informed that ten areas of mandatory training existed for staff members and a review of associated records found that none of these ten areas had been completed by all staff employed in the designated centre.

Staff files were not reviewed as part of this inspection.

Volunteers were not employed in the designated centre at the time of inspection or in the period since the time of the last inspection.

**Judgment:**
Non Compliant - Major

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

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<td>07 &amp; 08 December 2017</td>
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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 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:
There was an inappropriate mix of resident in the designated centre which was not based on assessed needs and age.

1. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
The policy for the admission and discharge of residents will be reviewed and updated to ensure that new admissions to the designated centre will be determined on the basis of transparent criteria. Where current residents are residing in houses which are not suitable, a transition plan to will be put in place to identify appropriate accommodation.

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
1. Contracts of care were not available for four residents.

2. The files of 19 residents contained only scanned images of one page of the written agreement and as such full contracts of care were not available.

**2. Action Required:**
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

**Please state the actions you have taken or are planning to take:**
An audit will take place of all residents to ensure that full contracts of care are available for each resident. Where the contract is not available, it will be uploaded.

**Proposed Timescale:** 15/03/2018  
**Theme:** Effective Services

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
A review found 23 resident files to have no details available with regards to the fees being charged for services provided.

**3. 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:**
A review of the finance policy is underway to confirm the charges residents incur. A review of the contract of care detailing the charges will take place. All residents and
their families will be provided with updated contracts of care for signing.

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

### 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:

Some areas of the designated centre required attention, including damage to plaster board and paint on walls which was chipping and damaged.

4. **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:**
An environmental audit will be carried out by the person in charge. The items requiring attention will be reported to the Technical Services Department who will address them in consultation with a Programme Manager. The Technical Services report on a monthly basis to the CEO regarding works completed.

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

**Theme:** Effective Services

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

Mould was observed on the ceiling of one bathroom in the designated centre.

5. **Action Required:**
   Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

**Please state the actions you have taken or are planning to take:**
The head of the household department has carried out an audit of the number of instances of mould in the designated centre and has addressed each instance. Regular audits of the bathrooms will take place. Where mould reappears, technical services who will contacted to address the cause.

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

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory
requirement in the following respect:
1. The showering facilities in one unit of the designated centre were found not to be of a satisfactory standard.

2. The arrangements in place for the safe disposal of general waste was found not to be satisfactory.

6. 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:
The head of the household department has assumed responsibility for ensuring bathrooms is of sufficient standard of hygiene. Regular audits will be carried out by the Programme Manager, the Person in charge and the head of household to ensure appropriate standards are maintained.
Where general items are for disposal, Technical services will remove it.

Proposed Timescale: 28/02/2018

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:
There was a clear and substantial absence of arrangements for the identification, investigation and learning from serious incidents resulting in poor outcomes for residents and exposing residents to ongoing serious risk of injury and harm.

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

Please state the actions you have taken or are planning to take:
a) The policy shall be reviewed so to include arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.
b) Incidents are reviewed for learning purposes within the house.
c) Risk is a standing item at the PIC Programme Manager.
d) The Risk Committee is a board subcommittee and presents directly to the board on a quarterly basis.
e) A risk report is presented to each Executive Management Team by the Risk Manager on a quarterly basis.
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was no emergency lighting in place in five areas of the designated centre all of which contained an emergency exit.

**8. Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
The floor plans shall be updated to ensure all emergency exits are clearly marked on the floor plans. All staff shall be provided with site specific fire safety training to ensure they know where the fire exits are. Where emergency lighting is required in the designated centre, this shall be fitted.

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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
1. Smoke detectors were found not to be in place in an area of one unit of the designated centre which contained a tumble dryer and washing machine.

2. Fire doors were found to be wedged open in three of the five units of the designated centre at the time of inspection.

**9. 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:**
Magnetic releases will be fitted to areas of high traffic volume. Where magnetic releases are not fitted, staff will be educated on the rationale for not wedging doors open and the Person in charge and programme manager will carry out regular checks to ensure that wedges are not used to keep doors open. Technical services shall audit rooms with tumble driers and washing machines. Where additional smoke detectors are required, they shall be fitted.

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

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requirement in the following respect:
A review of staff training records found that 15.9 per cent of staff members had not completed fire training in line with the organisation’s requirement.

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

Please state the actions you have taken or are planning to take:
The person in charge shall carry out a training audit. Where it is identified that staff have not completed fire safety training, they shall complete it.

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

**Theme:** Effective Services

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

1. Not all staff were aware of the required actions to take in the event of a fire.

2. In one unit of the designated centre it was found that a fire drill which reflected true staffing and resident ratios had not been completed in at least a three year period. While fire drills had been completed in this area in the intervening time period, these had either a reduced resident number present or an increased staffing number present.

3. 63.5 per cent of staff members employed in the designated centre were found not to have participated in a fire drill.

11. **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:
Fire Drills will be carried out with all staff in the designated centre to ensure that all staff are aware of the procedure to be carried out in a fire drill. On site training will be carried out by the PIC to ensure staff are aware of the evacuation routes and the location of firefighting equipment. An audit will take place of all staff to ensure all staff have attended fire safety training, including the use of fire fighting equipment. Where staff have not attended, they will attend.

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

**Outcome 08: Safeguarding and Safety**
**Theme:** Safe Services

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Allegations or suspicions of abuse were not identified as safeguarding concerns and as such were not reported in line with the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (Health Service Executive, 2014).

12. **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:
All allegations or suspicions of abuse shall be reported to the Designated Officer and screened under the Safeguarding Vulnerable Persons at Risk of Abuse Policy.

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

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Six incidents of abuse were not investigated.

13. **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:
The Person in Charge shall audit the incident reports and ensure all incidents of abuse are reported and investigated under the Safeguarding Vulnerable Persons at Risk of Abuse Policy.

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

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
In two separate units of the designated centre inspectors observed residents using toilet facilities with doors opened and privacy and dignity not maintained. In both instances, inspectors observed staff members walking past the toilet areas with the doors opened and not take action to address the compromised privacy and dignity of the residents involved.

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

**Please state the actions you have taken or are planning to take:**
The importance of maintaining resident’s dignity and respect shall be discussed at team meetings with all staff. The person in charge and Programme Manager shall highlight the importance of this at supervisions and competency assessments. All staff shall be assessed regarding their understanding and implementation of the Intimate and Personal Care Policy.

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
1. Inspectors found the knowledge of the types of abuse and the actions to taken in the event of suspecting or witnessing abuse of those spoken with to be wholly unsatisfactory.

2. A review of staff training records found that only 4.8 per cent of staff members employed in the designated centre had completed training in 'safeguarding vulnerable persons awareness programme'.

15. **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:**
All staff shall be trained in the Raising Awareness of Safeguarding Vulnerable Persons at Risk of Abuse Programme. All staff shall be assessed in their understanding of safeguarding, the types of abuse and the response to abuse through supervision with the Person in Charge and competency Assessments with the Programme Manager.

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

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
1. There were no healthcare plans in place in some instances to address residents' identified healthcare needs.
2. Some health care plans in place did not guide staff practice.

3. There was an absence of effective systems in place to ensure that all healthcare needs were reviewed and appropriately followed up on.

16. **Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**
All nurses have been trained in effective care planning. The care planning format has been reviewed and updated to promote effective review. All care plans are being reviewed to ensure that they are effective and guide practice. Staff’s understanding of the healthcare needs of residents is being assessed through individual supervisions with the Person in Charge and care staff assessments with the Programme Manager.

**Proposed Timescale:** 30/06/2018
**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that there was sufficient input and review of the healthcare needs of residents by allied health professionals.

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

**Please state the actions you have taken or are planning to take:**
The review of the healthcare needs of residents shall take place at least annually. This review shall include an OK Health Check Assessment, and medical review by a GP and multidisciplinary review by all allied health professionals involved in supporting the resident. Where a healthcare need is identified, it shall be met and a care plan shall be developed. The Director of Nursing shall establish a schedule of review of plans for residents and shall circulate same to all allied health professionals for their input. This review shall include the effectiveness of the plans. The recommendations arising out of a review shall include any proposed changes to the personal plan, the rationale for any such proposed changes and the names of those responsible for pursuing objectives in the plan within agreed timescales. Minutes of the review shall be recorded in the personal support plan of the resident and shall include all those who participated in the review.

**Proposed Timescale:** 30/06/2018
**Theme:** Health and Development
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents in four units of the designated centre were not supported to purchase, prepare and cook their own meals.

18. **Action Required:**
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

**Please state the actions you have taken or are planning to take:**
Menus shall be discussed at the weekly residents meetings. Where residents express a wish to prepare their own meals, this shall be facilitated by staff who shall support residents to go to the local supermarket to purchase preferred items and assist them as required to prepare and cook their own meals. Staff shall have access to a household cash float to fund this.

**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:
1. In the cases of the four residents who had records reviewed by inspectors, it was found that total daily fluid and dietary intake was not satisfactory.

2. In the case of one resident who was supported with fluid and dietary needs through the use of a transgastric tube, records reviewed stated that the resident had not received the recommended 1600mls of fluid or nutritional feed on at least four days of the period reviewed by the inspectors.

19. **Action Required:**
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident’s individual dietary needs and preferences.

**Please state the actions you have taken or are planning to take:**
The recording of fluid and dietary intake has been reviewed to allow staff easy access to allow accurate recording. A dietician has been appointed who has reviewed all residents at risk of dehydration. Where residents require PEG feeds, the Dietician is reviewing on a monthly basis.

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

**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:
1. A review of medication administration records by inspectors found seven occasions where medications were prescribed but not administered to two residents. No incident reports were found to have been completed to reflect these medication errors.

2. In one unit of the designated centre a staff nurse was observed preparing medications for administration and leaving these unattended while attending to another matter.

3. Two medications were observed to have been crushed while these were not prescribed to have been administered in this manner.

20. **Action Required:**
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

**Please state the actions you have taken or are planning to take:**
All nurses will be assessed to establish competency in medication administration. The medication administration policy has been updated to reflect medication errors and all houses have been provided with a flowchart for responding to medication errors. All errors must be reported to the Director of Nursing.

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**Proposed Timescale:** 25/02/2018

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Risk and capacity assessments were found not to have been completed with regards to residents taking responsibility for the self administration of medication.

21. **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:**
All residents shall be assessed to determine capacity to self-administer.
**Proposed Timescale:** 30/03/2018

**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:

1. The management systems in place in the designated centre had not ensured that the service provided was safe in particular in relation to safeguarding, healthcare, health and safety and risk management, fire safety, medication management, and workforce.

2. The services provided and systems in place were not appropriately monitored. Issues of concern were not identified or acted upon. The auditing systems in place, including the unannounced six monthly visits, either failed to recognise issues of concern or to act on presenting trends particularly to incident management and risk to residents' safety.

**22. 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 designated centre has been reconfigured to increase the number of Persons in Charge from one to three. The person in charge has responsibility for one or two houses and are at least .5 supernumerary to ensure appropriate oversight. Additionally, Programme Managers carry out visits to the house to carry out audits on progress on action plans and staff understanding and implementation of plans. The registered provider carries out 6 monthly audits in each house. Monthly management meetings are held with the CEO to report progress on addressing safeguarding, risk management, fire safety, workforce and medication management concerns.

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

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Inspectors were not assured that the number of staff was appropriate to the number and assessed needs of the residents availing of the services of the designated centre.

**23. 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 person in charge, with the Workforce Planning Office, shall review the number of staff of the designated centre to ensure they are appropriate to the assessed needs of the residents. Where a deficit is identified, the Person in Charge shall submit a business case to the Director of Care and the staff needs shall be provided.

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

**Theme:** Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that there was a significant reliance on agency staff within the designated centre which did not ensure that residents received continuity of care and support.

**24. Action Required:**
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
The person in charge is now managing the roster with support from the Workforce planning Office. A recruitment drive is underway to recruit vacancies within the designated centre. Where agency staff is required to fill posts on an interim basis, the same staff shall as much as possible be assigned to the house. Where staff have to move to cover another area, this shall only be with permission of the Programme Manager. All staff shall be inducted in the areas they are working.

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

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that staff duty rosters were poorly maintained in the designated centre and complete names for staff and times of duty were not consistently recorded.

**25. 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:
Persons in charge are now managing their rosters with support where required from the Workforce Planning Office. Persons in Charge are now completing their actual rosters and reviewing them on a weekly basis.
Proposed Timescale: 18/02/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that none of the ten mandatory areas of training had been completed by all staff employed in the designated centre.

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

Please state the actions you have taken or are planning to take:
The Person in Charge shall carry out a training audit. Where it is identified that staff have not completed mandatory training, they shall complete it.

Proposed Timescale: 30/03/2018