<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Adults Services Palmerstown Designated Centre 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003903</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Dublin 20</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Stewarts Care Limited</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Thomas Hogan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Ciara McShane (day 1 only); Michael Keating (day 2 only)</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>27</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>5</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 December 2017 09:00</td>
<td>11 December 2017 19:40</td>
</tr>
<tr>
<td>12 December 2017 09:00</td>
<td>12 December 2017 17:10</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome 07: Health and Safety and Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12. Medication Management</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
</tr>
</tbody>
</table>

**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 three inspectors. At the time of the last inspection (01 June 2017) inspectors found all six 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. A representation document 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 four detached buildings which provided residential services to 27 persons with disabilities at the time of inspection.
In the time since the last inspection, one of the four individual units was closed by the service provider to allow for renovations to be completed. This unit remained closed at the time of this inspection and as a result the inspection took place in the remaining three units.

How we gathered our evidence: Inspectors met with 17 of the residents availing of the services of the centre and spoke with eight staff members, persons in charge, the programme manager, and the director of care. Various sources of documentation, which included a 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: Six outcomes were inspected against as part of this inspection and overall the inspectors observed a very high level of regulatory non-compliance. All six outcomes were found to be in major non-compliance with the Regulations. In addition, of the 24 actions followed up on from the previous inspection, it was found that 15 had not been satisfactorily addressed by the provider. Significant concerns were identified at the time of this inspection in the areas of healthcare, medication management, fire safety, and safeguarding 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 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 or 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.

Three of the eight 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 reviewed a sample of 34 incident reports relating to incidents which had occurred in the designated centre in September, October and November 2017. Of these, inspectors found that 14 incidents related to allegations or suspicions of abuse. Six of these incidents were found not to have had appropriate follow up in place. Seven further incidents related to slips, trips or falls of residents and six of these incidents were also found not to have had appropriate follow up completed.

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 a staff member spoken with, who had been employed in the unit for three years, confirmed that they had not completed a simulated fire drill in that unit at any time. This staff member outlined that they were responsible for the care of nine individuals at night time in a single staff arrangement, and when asked stated that there would be an expected response from ten support persons in the event of a fire at night. From a review of records only three persons responded at the time of the last fire incident in
Inspectors found that of the four staff members spoken with regarding fire safety, two conformed that they had not read the personal emergency evacuation plans for residents. In addition, one staff member outlined that they were not confident that all residents could be evacuated to safety in the event of a fire with the current staffing levels in the designated centre.

A review of staff training records found that 72 per cent of staff members employed in the designated centre were found not to have participated in a fire drill. In addition, 19 per cent of staff members had not completed fire training in line with the organisation's requirement.

A review of the designated risk register by inspectors found that only two areas had risk registers in place. One area had four risks listed with corresponding control measures. The risks listed were: slip/trip/fall; behaviours of concern; choking; and fire. The risk of abuse towards residents was found not to have been considered for this area of the centre. In a second area, five risks were listed including safeguarding of residents. Control measures listed on this document were found not to be in place at the time of inspection. For example, a control measure listed under fire stated: "fire training for all staff", however, this had not occurred as outlined previously in this outcome.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
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 nature 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, allegations, or suspicions abuse had not been appropriately followed up on. Three of these incidents related to peer to peer physical abuse, while the remaining three incidents related to unexplained injuries sustained by residents. Inspectors identified that these six incidents of alleged or suspected abuse had not been notified to HIQA by the provider as required.

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. Overall, inspectors found the knowledge of staff members of the types of abuse and the actions to taken in the event of suspecting or witnessing abuse of those spoken with to be mixed and unsatisfactory.

A review of staff training records found that only 36 per cent of staff members employed in the designated centre had completed training in 'safeguarding vulnerable persons awareness programme'.

Inspectors found that excessive noise levels in one unit of the designated centre did not promote dignity and respect of residents. An inappropriate mix of residents availing of the services of this unit resulted in some individuals vocalising loudly on a continuous basis while impacting negatively on others. When spoken with, the person in charge acknowledged that environmental concerns identified contributed negatively to residents lived experience of the designated centre and overall mental health needs.

A review of restrictive practices in the designated centre by inspectors found an additional six restrictions in place which had not been identified by staff members or the management team.

Inspectors reviewed behaviour support plans in place for residents in one unit of the designated centre and found that five individuals who required plans to support the management of behaviour did not have these in place. The person in charge outlined that a process of prioritization was underway for the completion of behaviour support plans across the service.

**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 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 health care needs of residents, inspectors identified serious concerns relating to nutritional and fluid intake of residents, and health care plans in place in the designated centre to guide practice.

A review of daily nutritional and fluid intake records of three residents was completed by inspectors. In the case of one resident, who had a recommended daily fluid intake of 1,588 milliliters outlined in a hydration assessment, a review of ten days of fluid intake records found that on seven days the minimum intake was not achieved. Records identified that on one of the days reviewed a total intake of 505 milliliters was recorded and on another day a total of 750 milliliters was recorded. A further day had no fluid intake recorded for the resident. This resident had been last seen by dietetics in October 2015 and was recommended a follow up review four weeks after this.

Inspectors found that in the case of one resident the total daily nutritional intake was not satisfactory and had not been identified as a concern by the staff team. In addition, inspectors found that another resident, who was identified as experiencing unexplained weigh loss and had lost 10 kilograms in a 14 month period, had been classed as 'malnourished' on a recent assessment, however, had not been seen by dietetics since October 2014.

A review of health care plans in two units of the designated centre found that 19 health care issues identified by the staff nurses did not have corresponding health care plans in place. In the case of one resident, a health care plan was found not to be in place for epilepsy. Other health care conditions were corresponding health care plans were not in place included neuralgia, ongoing conjunctivitis, anemia, reduced bone density, constipation, hypothyroidism, depression/low mood, osteopenia, and hypercholesterolemia. Inspectors found that overall, health care plans which were in place in the designated centre did not sufficiently guide staff practice. In addition, inspectors found that plans were not reviewed on at least an annual basis with multidisciplinary involvement.

**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):**  
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.

A review of medication administration records found that five separate prescribed medications were not administered to four residents on 55 occasions in the time period reviewed by inspectors.

Inspectors found that 13 residents availing of the services of the designated centre did not have assessments of capacity or risk completed relating to the self-administration of medication.

A review of medication storage facilities found that medications contained were stored appropriately and were within the individual specified expiry dates listed.

**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.

Inspectors identified that significant concerns remained regarding healthcare, medication management, safeguarding and fire safety in the designated centre. Management systems failed to appropriately recognise these concerns and/or act accordingly to address significant risks.

Inspectors found that all four of the units in the designated centre had a Regulation 23 unannounced six monthly visit completed in the six months prior to the inspection. Unannounced visits were completed on 24 July 2017, 15 September 2017, 25 September 2017, and 24 November 2017. Reports summarising these unannounced visits were made available to inspectors. It was found that in two cases the unannounced visits did not involve consultation with either residents, their families or representatives. In another instance, there was no recorded consultation with any staff member working in the area. A review of incident and accident did not take place in three of the four completed unannounced visits. Inspectors found that the unannounced visits process failed to identify serious concerns which presented ongoing risk to residents.

Inspectors were informed that the designated centre was in the process of reconfiguration and, in the time since the last inspection, additional persons in charge had been recruited. Notification of these appointments had not been made to HIQA, however, on the day of inspection the arrangements for the governance and management of the designated centre remained unclear for residents and staff members. The manager who identified themselves as the person in charge outlined the current arrangements to the inspector. It was found that arrangements in place were not satisfactory and did not provide for adequate governance and management of the centre. A person participating in management outlined that an additional person in charge was being recruited and once overall reconfiguration of management structures was completed, there would be a named person with responsibilities for all three operational units of the designated centre.

During discussions held with the director of care and programme manager, it was highlighted that significant restructuring had taken place and remained ongoing at senior management and board levels within the wider organisation. Changes involved appointment of an additional programme manager, a new director of nursing, and a recently appointed new chair of the board of directors.

**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 that overall the number and skill mix of staff on duty in the designated centre at times was not appropriate to the number and assessed needs of residents. Staff were not sufficiently knowledgeable of residents' needs and support requirements. Appropriate supervision arrangements were found not to be in place.

Staff members spoken with informed inspectors that staffing numbers dropped below the minimum required numbers in the designated centre on a regular basis. A review of staff duty rosters outlined significant variations in staffing levels and in one area of the designated centre it was found that staffing levels varied from six staff members between the hours of 08:00am and 8:15pm on one weekday to four on the following day, to three on the third day.

Staff training records for mandatory courses were reviewed by inspectors and while it was found that 100 per cent of staff had completed break away techniques training, significant gaps were identified in other areas. It was found that only 28 per cent of staff had participated in a fire drill, 81 per cent had attended fire training, 83 per cent had complete manual handling training, and 83 per cent had completed hand hygiene training. Staff training deficits relating to safeguarding vulnerable persons training was addressed under Outcome 8 previously in this report. A training plan was in development to address the gaps in mandatory training by the person in charge following an audit of this area.

Arrangements for the supervision of staff were found not to be satisfactory by inspectors. While a new structure of management was in development and being introduced to the designated centre, it had not resulted in satisfactory supervision of staff at the time of the inspection. One area of the centre was found to be without an identified responsible manager at the time of inspection. Staff members spoken with outlined that while formal supervision sessions did take place, they were not regular and the timescales involved breeched the organisational policy on this matter.

The person in charge confirmed that no volunteers were employed in the designated centre.

Staff files were not reviewed as part of this inspection.
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:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Stewarts Care Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003903</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>11 and 12 December 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>11 May 2018</td>
</tr>
</tbody>
</table>

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 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 resident to ongoing serious risk of injury and harm.

The personnel identified by the provider as responsible for the identification and
management of adverse incidents and risk had failed to fulfill these responsibilities.

1. **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:**
The risk management policy shall be reviewed to ensure that it includes arrangements for the identification, recording and investigation of and learning from serious incidents or adverse events. All incidents shall be reported on the National Incident Management System. The PPIM/ PIC shall ensure that incidents are standing agenda items at team meetings for learning purposes. PPIM's/ PIC's shall report on a weekly basis to the Programme Manager on the number and management of incidents to ensure follow up and promote learning. All PICs/PPIMs shall be trained in the accurate reporting of incidents on the National Incident Management System.

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
19 per cent of staff members had not completed fire training in line with the organisation's requirement.

2. **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:**
An audit shall be carried out identifying staff in need of fire safety training. All staff shall complete fire safety training no less that every two years as per organisational requirement.

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

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Two members of staff spoke with confirmed that they had not read the personal emergency evacuation plans of residents for whom they were providing care and support.
A review of staff training records found that 72 per cent of staff members employed in the designated centre were found not to have participated in a fire drill

3. **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:**
All staff shall be instructed to read the fire evacuation plans and shall be assessed on their understanding of same during supervision/ care.
All staff shall participate in a fire drill.

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

---

**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 significant number of residents did not have a plan in place to support them with behaviours which challenge.

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

**Please state the actions you have taken or are planning to take:**
Where residents are identified in need of behaviour support, a plan shall be developed to support them. All staff shall be assessed in their understanding of the behaviour support plans. All staff shall be trained in the implementation of the behaviour support plans.

**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:**
A review of restrictive practices in the designated centre by inspectors found an additional six restrictions in place which had not been identified by staff members or the management team.

5. **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:**
A restrictive practice audit shall be carried out to identify all restrictions within the designated centre. The Restrictive Practice policy shall be reviewed to ensure it guides practices. Staff shall be assessed as to their understanding of restrictions and the rationale for implementing same. Restrictive practices shall be reviewed and sanctioned as appropriate by the restrictive practices Committee. The implementation of the restrictive practice shall be logged along with its release. Where restrictive practices are implemented, efforts shall be made and recorded to ensure that this is the least restrictive, for the shortest period of time and is reviewed regularly.

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

**Theme:** Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Incidents, allegations or suspicions of abuse of residents were not identified as safeguarding concerns and as such were not reported in line with the national policy. As a result, adequate measures were not in place to ensure residents were safeguarded.

Inspectors found the knowledge of staff members of the types of abuse and the actions to taken in the event of suspecting or witnessing abuse of those spoken with to be mixed and unsatisfactory.

6. **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 of residents shall be investigated and reported in line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse Policies and Procedures. All staff shall attend the Raising Safeguarding Vulnerable Persons At Risk of Abuse Awareness Training. All staff shall be assessed on their knowledge and understanding on the types of abuse and the response to same. Where deficits in knowledge and understanding are identified, a training plan shall be put in place.

**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:  
Incidents, allegations or suspicions of abuse in the designated centre were not investigated.

7. 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:  
All incidents, allegation and suspicions of abuse will be investigated as per HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures.

**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:  
36 per cent of staff members employed in the designated centre had completed training in 'safeguarding vulnerable persons awareness programme'.

8. 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 will complete Safeguarding Training.

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

**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. Inspectors found that the dietary and fluid intake of residents was not appropriately monitored to ensure that appropriate and/or recommended intake was achieved.

2. A review of health care plans in two units of the designated centre found that 19 health care issues identified by the staff nurses did not have corresponding health care plans in place.

3. Inspectors found that overall, health care plans which were in place in the designated centre did not sufficiently guide staff practice.
9. 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:
a) Where there is a risk of dehydration or malnutrition, the Dietician shall review and monitor to ensure their needs are met.
b) The Director of Nursing shall meet with all nursing staff advising them of the schedule by which all residents will have an annual medical review and OK health check completed.
c) Where needs are identified, these shall be met.
d) All nurses shall be trained on the effective development and review of care plans.
e) Care plans shall be developed for all residents.
f) The recording of fluid intake shall be completed on a regular basis.
g) A campus wide audit shall take place to assess staff knowledge, understanding and implementation of plans for residents. Where there is a gap in their knowledge and skills, a training plan shall be developed.
h) Persons in Charge shall also assess knowledge during supervisions

Proposed Timescale:
a) 24/02/18
b) 31/01/18
c) 31/01/18
d) 30/6/18
e) 31/12/17
f) 15/12/17
g) 30/06/18
h) 31/01/18

Proposed Timescale: 30/06/2018

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:
A review of medication administration records found that five separate prescribed medications were not administered to four residents on 55 occasions in the time period reviewed by inspectors.

10. 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:
An audit shall be carried out to ascertain the scale of medication errors. This audit shall be shared with the Director of Nursing and actioned, including, review by GP for effects on residents and competency assessments for the nurses. At an organisation level, all nurses have been assessed for their competency in medication administration. The medication policy has been reviewed to provide clear direction on the procedures for ordering, receipt, prescribing, storing, disposal and administration of medication.

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:
Inspectors found that no risk assessments or capacity assessments had been completed regarding the self administration of medication by residents in the designated centre.

11. 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:
An audit will be carried out identifying the residents for whom assessments have not been complete. Where assessments have not been completed, they shall be completed.

Proposed Timescale: 30/04/2018

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 management systems in place in the designated centre had not ensured that the service provided was safe in particular in relation to the provision of healthcare, fire safety and safeguarding.

12. 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 of the designated centre has been reconfigured to increase the number of
Persons in Charge from 1 to 4. Until the reconfiguration is agreed with the Authority, each home in the designated centre shall have a named person responsible for the person in charge responsibilities within the home. These are based within their area of responsibility. There is a recruitment drive underway to recruit the remaining vacancy. Persons responsible are required to appoint shift leaders in their absence who shall report to the Programme Manager. A schedule of audits shall be implemented to provide oversight to ensure the effective monitoring of services. Weekly reports shall be sent to the Programme Manager provide oversight to the management of the centre. Regular visits shall be scheduled by the Programme Managers to carry out announced audits. The competency of all staff shall be assessed by an appropriate manager through supervision and competency assessments.

**Proposed Timescale:** 30/05/2018  
**Theme:** Leadership, Governance and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Inspectors found in two cases that completed unannounced visits did not involve consultation with either residents, their families or representatives. In another instance, there was no recorded consultation with any staff member working in the area.

A review of incident and accident did not take place in three of the four completed unannounced visits.

Inspectors found that the unannounced visits process failed to identify serious concerns which presented ongoing risk to residents.

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

**Please state the actions you have taken or are planning to take:**
A schedule or unannounced inspections has been developed and shall be carried out by an external consultant. The template suggested by the Authority shall be used to focus the audit. The action plan shall be developed with the Person in Charge. The auditor shall meet with the Director of Care and the Chief Executive on a monthly basis to discuss findings from the audits. The Programme Manager shall meet with the PPIM/ PIC on a 2 monthly basis to discuss the progress of the action plans.
### Proposed Timescale: 01/01/2018

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The number of staff on duty at time in the designated centre was not in accordance with the required levels and assessed needs of residents.

14. **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 staffing complement requirements to meet the needs of the residents has been identified and there is a recruitment drive underway to recruit vacancies. Where deficits are identified, agency staff are utilised on an interim basis. Agency booking is being managed through the Workforce Planning Office to ensure agency staff are assigned to familiar areas.

### 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:
Significant gaps were identified in mandatory training areas including safeguarding training, participating in a fire drill, fire training, manual handling training, and hand hygiene training.

15. **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:
An audit shall take place to identify gaps in training needs of staff in areas of core competency. Where gaps are identified, staff shall be trained.

### Proposed Timescale: 30/07/2018

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised either directly or through formal supervision processes.

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

Please state the actions you have taken or are planning to take:
The structure of the designated centre has been reconfigured to increase the number of Persons in Charge from 1 to 4. Until the reconfiguration is agreed with the Authority, each home in the designated centre shall have a named person responsible for the person in charge responsibilities within the home who shall work within their area of responsibility to ensure direct supervision. There is a recruitment drive underway to recruit the remaining vacancy.
Persons responsible are required to appoint shift leaders in their absence who shall report to the Programme Manager.
Regular visits shall be scheduled by the Programme Managers to carry out announced audits.
The competency of all staff shall be assessed by an appropriate manager.
All staff shall receive formal supervision quarterly as per organisational policy.

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