### Centre name: Ox View Community Houses
### Centre ID: OSV-0004431
### Centre county: Sligo
### Type of centre: The Health Service Executive
### Registered provider: Health Service Executive
### Lead inspector: Catherine Glynn
### Support inspector(s): Thelma O’Neill
### Type of inspection: Unannounced
### Number of residents on the date of inspection: 21
### Number of vacancies on the date of inspection: 1
About monitoring of compliance

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

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

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

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

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

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

The inspection took place over the following dates and times
From:  
13 December 2017 11:15  
14 December 2017 09:10
To:  
13 December 2017 19:00  
14 December 2017 18:00

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

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Summary of findings from this inspection
Background to inspection:
Following ongoing failure by the provider to address areas of non-compliance which were impacting on the safety and quality of life for residents, the Health Information and Quality Authority (HIQA) issued the provider with a Notice of Proposal to cancel the registration of the centre on 30 November 2017. As allowed in the Health Act 2007 (the Act), the provider made representation to the Chief Inspector setting out the actions that had been put in place to respond to the grounds for proposing to cancel their registration. Following representation made by the provider, (HIQA) conducted a monitoring inspection on the 13 December 2017 to verify if the
representation from the provider had been implemented as stated. The inspector found that the representation had not been fully implemented as stated and this was having a negative impact on the service provided and the quality of care delivered to residents. Although resources were now allocated to address the failings identified on the previous inspections, additional assurance relating to safeguarding were required following this inspection within a specified time period by HIQA. The representation response also stated that the governance and management arrangements within the centre had been further enhanced and formalised; however, inspectors found that there continued to be evidence of poor oversight and management in place in the centre.

As part of this inspection, the inspector reviewed the proposed actions as detailed in the provider’s representation response to the notice of proposal to cancel their registration for this centre. The inspector also reviewed the 33 actions the provider had completed since the last inspection. The inspector found that a number of actions had not been addressed satisfactorily.

How we gathered our evidence:
As part of this inspection, inspectors completed a walk around of the centre, observed residents in the designated centre, as they were unable to verbally communicate with the inspector and also spoke with eight residents who were happy to speak with them. Inspectors also met with eight staff members, including the person in charge, provider's representative, designated officers, two clinical nurse managers and senior management. Inspectors noted that all residents were treated in a respectful manner at all times and supported in line with their assessed needs. The residents were familiar with the staff and managers present on the day of the inspection and appeared calm and relaxed throughout the inspection. Inspectors also observed interactions between residents and staff and their work practices. Documentation such as personal plans, risks assessments, medication records, healthcare plans and emergency planning within the centre was also reviewed.

Description of the service:
The provider had produced a document called the statement of purpose, as required by the regulations, which described the service provided. Inspectors found that the service was being provided as described in that document. The centre comprised of five houses located in County Sligo. These houses were located in close proximity to local amenities such as cafes, shops, pubs and restaurants. Residents also had access to vehicles which enabled them to access leisure facilities and shops in the town. There was also access to local public transport for some houses and taxi services when required.

Overall judgment of our findings:
Inspectors found that improvement had occurred in three of the five houses. Significant improvements had been made to the quality of care delivered to residents on the designated centre; however further improvement was required to ensure that all actions identified were addressed in a timely and satisfactory manner. The provider had also implemented aspects of the representation made to HIQA within the stated timelines. Inspectors found that these improvements had a positive effect on the lived experience of residents in the designated centre. Outcomes included
family and links with the community, social care needs, access to specialised supports, and resources were found to be in compliance. Governance and management, safeguarding, and workforce remained the significant area of concern, as inspectors found that these actions arising from the last inspection had not been satisfactorily addressed. The quality of some of the premises in the centre required further improvement as facilities provided were not adequate or in-line with requirements; and the management team were still required to address actions as identified in the last inspection report to improve the overall living environment for residents. Of the 18 outcomes reviewed; eight were compliant, three were substantially compliant, four were in moderate non-compliance and three were major non-compliant.

The outcomes and their findings are further discussed in the main body of the report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents were aware of their rights and were involved in aspects of the running of the centre. However, inspectors found that improvement was required to the management of complaints.

The provider’s complaints policy was up-to-date and displayed on communal notice boards in each of the houses alongside information about the centre’s nominated complaints officer. In addition, an easy-to-read version of the policy, as well as information on the Health Service Executive’s confidential recipient and advocacy services, was also displayed on the communal notice boards. Staff told the inspector that residents were asked if they were happy at the centre and had any complaints at the weekly residents’ meetings, and their knowledge reflected the provider’s policy.

A record of all complaints received was maintained at the centre, which included a description of the complaint. In addition, the inspector met with residents during the inspection who said that if they were unhappy with any aspect of the centre they would speak with the staff on duty or the person in charge. However, improvement was required as no record of satisfaction of the complainant had been documented.

Residents told inspectors that they participated in weekly residents meetings and would decide what activities they wished to do in the week when not at day services, as well as the menu planning and talking about if they had any complaints about the centre. Residents’ meeting minutes also showed that they were used to provide residents with information on advocacy services, keeping safe and fire safety.
Residents told the inspector that they were visited regularly by their families and were supported to have overnight stays, which were also reflected in discussions with family members and staff. The centre's layout also provided facilities for residents to meet their visitors in private.

The inspector reviewed arrangements for supporting residents with their personal finances and found that they were managed appropriately.

Residents accessed a range of activities in the local community as well as day services in the local area. Some residents were supported with individualised care and arrangements were in place to support them at home and facilitate community based activities during the week, which reflected residents' interests and preferences. Residents told the inspector that they went out for meals did personal shopping, planned and went on holidays both in Ireland and abroad and attended both music concerts and sporting events, which reflected their personal goals and were recorded in activity records examined.

Throughout the inspection, staff supported residents in a timely, dignified and respectful manner which reflected their assessed needs. Residents told the inspector that they liked the staff and they helped them a lot. Where residents were unable to tell the inspector about the support they received, they appeared both relaxed and comfortable and showed no signs of distress with any support provided by staff during the inspection.

**Judgment:**
Substantially Compliant

**Outcome 02: Communication**
*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
The inspector found that residents were supported to communicate their needs.

Residents' personal plans included an assessment of their communication needs and indicated any communication aids required. The inspector found that staff knowledge and observed practices on the days of inspection reflected residents' communication needs as described in personal plans examined.

The centre provided easy-to-read versions of residents' personal plans and written
agreements, as well as the centre's complaints policy and a pictorial fire evacuation plan. Residents also had access to a range of media at the centre such as radio and television.

**Judgment:**
Compliant

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

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
Residents were supported to maintain family and personal relationships and to engage in activities in their local community.

The provider had an up-to-date visitor's policy and provided facilities for residents to meet their families and friends in private such as seating areas in conservatories and porches.

Residents told the inspector that they were regularly visited by family members and supported by the centre's staff to go home for overnight stays. The inspector did not meet with family members during the inspection; however, records reflected they visited their relatives at any time without restriction and a log was maintained of all family contact.

Inspectors found that families were invited to their relatives' annual personal plan review meetings and kept up-to-date on progress or concerns which related to their relative's needs by the staff, which was reflected in records examined.

Activity records were reviewed and inspectors found that residents were supported to participate in a variety of activities in the local community such as day services, access local shops, leisure facilities and to go to local cafes, pubs and restaurants. Residents also told inspectors that they were supported to achieve their personal goals such as going on holidays or attend sporting events such as regular soccer and GAA fixtures and see their favourite country musicians in concerts. These residents' experiences were further reflected in discussions with staff and families.

**Judgment:**
Compliant
### 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 although residents had written agreements in place, some of these did not provide clear information on charges to be paid or had not been signed by the provider.

Residents had accessible written agreements in place at the centre; however, not all agreements reviewed included clear information on the charges to be paid. For example, inspectors found three copies of the agreement with three different rental amounts listed. In addition, a contract had not been updated to reflect changes that had occurred such as change of residence and the weekly rent payment did not reflect the staff or services provided in the house.

The provider had an up-to-date admissions and discharge policy which reflected the centre's statement of purpose. The centre had no new admissions prior to the inspection.

**Judgment:**
Substantially Compliant

### Outcome 05: Social Care Needs

**Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.**

**Theme:** Effective Services
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found that residents’ needs were reflected in their personal plans.

Inspector’s looked at a sample of residents’ personal plans, which included assessments on support needs such as healthcare, keeping safe, communication, behaviour that challenges, independent living skills and relationships. Personal plans were up-to-date and reflected both staff knowledge and observed practices on the days of inspection. The inspector found that personal plans were available to residents in an accessible format which presented information through a mixture of photographs, symbols and words.

Personal plans were reviewed annually, one resident’s annual review was outstanding at the time of inspection, although this was scheduled to occur within the next month. Where personal plans had been reviewed, records showed that meetings were attended by the residents, their families, centre staff and associated multi-disciplinary professionals such as psychiatrists and social workers.

Furthermore, meeting minutes showed that all aspects of the resident's personal plan had been assessed including healthcare needs, behaviours of concern, medication and personal goal progress. Following review meetings, inspectors found that both personal plans had been updated with any agreed recommendations.

Additional staffing had been provided to support social activities and opportunity to engage in the local community.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
Overall, inspectors found that three of the five houses were well maintained and the design suitable to meet the assessed needs of residents; however, further improvement
was required to bathroom facilities in two houses.

The centre comprised of five houses, some were single-storey and others were two-storey dwellings, located throughout Sligo county. The centre had access to local amenities such as cafes, public houses and leisure facilities. Each house comprised of four or five resident bedrooms. Some bedrooms were equipped with overhead hoists to support residents mobility needs.

Inspectors found that bedrooms were all individualised and had also been decorated to residents personal choice. Family photos, pictures of music events and other items which reflected their interests, were displayed throughout each house. All bedrooms had sufficient storage space for clothing and personal items.

The houses had sufficient communal bathrooms; however, further improvement was required for two houses. In one house, bathrooms did not have adequate space to access the facilities and did not allow safe movement for staff to support residents, based on the assessed needs. In addition, there was no hand washing facility in an en-suite provided, to ensure infection control was maintained. The main bathroom did not have splash guard in place and no precautions were in place to prevent slips, trips or falls.

In another house, an en-suite facility did not have measures in place to prevent slips, trips or falls.

The person in charge had an office located in one house within the centre. The centre's garden areas were well-maintained and accessible to all residents.

Inspectors observed suitable arrangements were in place for the safe disposal of general and clinical waste throughout the centre, and laundry facilities were provided in each house.

Judgment:
Non Compliant - Moderate

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 did not cover all aspects of this outcome, but focused on actions arising from the last inspection and representation received. Improvement was found with regard to
fire safety and installation of fire measures required; however, further improvement was required to ensure that comprehensive reviews of all risk assessments were completed.

The provider had ensured that fire doors were in place in all houses within the centre. In addition, fire panels had been relocated to ensure that they were no longer placed in an inaccessible area. Fire drills were being completed and records were maintained of all drills completed. This included staff who supported residents and all residents who engaged in this process. Learning was also identified to aid further fire drills.

Since the last inspection, inspectors found that risk management required further significant improvement. Staff had received training in risk management and attendance was confirmed on training records. On review of risk assessments in personal plans, inspectors noted that slips, trips and falls risks were not identified or assessed where bathrooms with inadequate facilities were located. In addition, no multidisciplinary (MDT) support or reviews were provided to guide staff in this risk management. This review was required by a comprehensive MDT as some residents had mobility issues and required mobility aids. Some bathrooms were also limited in space and affected personal care being provided. The person in charge had failed to identify these risks and escalate the risk appropriately.

Hand hygiene and infection control information was displayed throughout the centre; however, lack of hand washing facilities for some residents did not ensure they were supported to maintain hand washing, in-line with the organisational policy. For example, a hand basin had been removed in an en-suite and had not been replaced at the time of inspection.

The centre had access to vehicles, for each house within the centre. Where required vehicles were adapted for wheelchair users. Records showed that vehicles were roadworthy, well maintained and suitable taxed and insured.

**Judgment:**
Non Compliant - Moderate

### Outcome 08: Safeguarding and Safety

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

**Theme:**
Safe Services

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

**Findings:**
Overall, inspectors found that residents were protected from potential abuse in four out of five houses in the centre. However, the provider had failed to address three actions from the last inspection. The provider had failed to ensure that residents were protected from abuse and that all concerns were appropriately investigated in-line with local and national policy.

During this inspection, inspectors found that there were three incidents of allegations of abuse recorded. This was evident from the 5 of November until the 16 of December 2017. Staff had been advised to record all concerns in a recording book, which they had fulfilled. However, the person in charge had failed to ensure that all concerns raised were alerted to the designated officer for further review to ensure preliminary screening was commenced or completed. The designated officer or management did not discuss these concerns or provide residents' the opportunity to discuss these allegations. In addition, there were no records of further investigation from the date of the safeguarding concern was first recorded. Incident forms were not utilised and therefore the incident review group had not been alerted to the number of incidents to ensure a robust review of the concerns were completed.

Inspectors found that a new staff had commenced in October 2017 in the centre; however, the management had not provided this staff with appropriate training in safeguarding. The person in charge informed inspectors that they had verbally informed the staff of the guidelines in place; however, this was not in-line with local policy. There was also no date specified for completion of this training, at the time of inspection.

On the day of inspection, when this became evident, the person in charge and designated officer immediately acknowledged the lack of oversight and commenced a formal investigation. Assurance was sought from the person in charge regarding ensuring that all concerns, allegations or queries of abuse were appropriately investigated, in-line with local policy to ensure all residents were supported and safe in the centre.

Inspectors found that there were policies and procedures in place that guided staff and to promote a safe environment. However the designated person had failed to address the compatibility needs for all residents regarding the impact of residents who presented with behaviours that challenge. Compatibility assessments had been completed as required; however, inspectors found that three of the assessments identified that residents were not compatible and did not enjoy the current living arrangements. Inspectors found that while the assessments were completed, there was no plan in place to address the issues that were raised and no timeframes for completion.

The provider had made changes to the capacity of the centre by transferring a resident from one house to another in the centre. This had improved the living arrangements in place, which provided more space and opportunity for residents to have privacy if needed.

On review of training records, inspectors found that bespoke training for behaviour
management, had been provided to staff in the centre.

**Judgment:**  
Non Compliant - Major

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<th>Outcome 09: Notification of Incidents</th>
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<td><strong>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</strong></td>
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**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 although the centre maintained a record of all notifications submitted to the Health Information and Quality Authority (HIQA), not all notifications had been submitted within regulatory timeframes and incidents had not been identified as notifiable events.

A record of all notifications submitted to HIQA was kept at the centre including all notifications submitted under schedule 4 of the regulations. However, inspectors found that not all notifications which related to allegations (confirmed or suspected of abuse towards a resident) had been submitted in-line with regulatory timeframes.

In addition, inspectors found that any serious injury to a resident which requires immediate medical or hospital treatment had not been notified with required timeframes.

**Judgment:**  
Non Compliant - Moderate

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

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors found that residents accessed individualised day services and social activities, which reflected their assessed needs, preferences and interests.

The provider had an up-to-date policy on supporting residents to access education and training, which was reflected in the centre's statement of purpose. In addition, residents' educational and training needs were assessed as part of their personal plan and reflected staff knowledge.

Residents told the inspector that they attended a range of day services in the local area which they enjoyed. One resident had expressed a desire to do paid work as a goal and records showed that they had been supported by staff to investigate work opportunities. Personal plans showed that residents were supported to develop independent living skills such as money recognition, cooking and household cleaning tasks.

Where able to, residents told the inspector that they access to a range of activities in the local community such as local shops, cafes, pubs, leisure facilities in-line with their interests and choices.

**Judgment:**
Compliant

### 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Residents were supported to access healthcare professionals and manage their health.

Inspectors reviewed residents' healthcare records and found that residents were supported to access a range of allied healthcare professionals in-line with their assessed needs. Records showed that residents attended appointments with healthcare professionals such as general practitioners, psychiatrists, medical consultants, physiotherapists, occupational therapists, chiropodists and dentists.

Residents’ personal plans included up-to-date information on their healthcare needs, which reflected staff knowledge. Where residents had dietary needs or weight management programmes in place, they had been supported to access both dietitians
and speech and language therapists, with these professionals' recommendations reflected in their personal plans.

Residents told the inspector that they chose the centre's meals as part of weekly residents meetings and daily discussions with staff. Where residents were unable to voice food choices, staff told the inspector that they indicated their preferences through gestures and actions as well as staff knowledge on their favourite meals, likes and dislikes.

Residents told inspectors that they were involved in preparing vegetables for meals at the centre as well as making sandwiches and drinks for themselves. Residents also said that they had opportunities to eat out in local cafes, restaurants and pubs as well as order takeaways, which was reflected in activity records and food diaries.

Food records maintained at the centre showed that residents had access to a varied and healthy diet as well as snacks and drinks throughout the day. Residents also told the inspector that they did the weekly grocery shopping with staff at local supermarkets which was reflected in activity records and discussions with staff.

**Judgment:**
Compliant

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**Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

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

**Findings:**
The inspector found that the centre's medication arrangements reflected the provider's policies and procedures; however, improvement was required to storage facilities and records.

Inspectors reviewed residents' medication administration records and found that they reflected prescription records and included residents' personal details - as well as information on administration times, route and dosage. The centre maintained an up-to-date signature bank of all staff trained to administer medication, which was part of the residents' medication administration records. Each resident's medication needs were part of their personal plan, the provider had not completed assessments on each resident's capacity to take responsibly for their own medication.
Inspectors reviewed protocols for the administration of 'as and when required' medication (PRN) such as emergency epilepsy medication. Protocols were up-to-date, provided information on the circumstances that each medication should be given including maximum dosages and reflected staff knowledge. Training records further showed that all staff who administered emergency epilepsy medication had received up-to-date training in this area.

Inspectors observed that medication was not securely stored in the centre. For example, on the day of inspection, inspectors found a medication cupboard which was not secure and accessible by all residents. Arrangements were in place for the segregated storage of out-of-date or discontinued medication. Records and staff confirmed that out-of-date or discontinued medication was returned to a local pharmacy for disposal.

Regular medication audits were carried out by designated staff in-line with the provider's policies and furthermore quarterly audits of the centre's medication practices were carried out by a named pharmacist on a quarterly basis from records and staff discussions. However, these audits failed to identify stock control issues regarding 'as required' medication. Inspectors found that there were a number of 'as required' tablets missing on the day of inspection and staff were unable to verify why this had occurred. Furthermore, inspectors found incorrect labelling of medication.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The statement of purpose reflected the services and facilities provided.

The previous inspection had found that the centre's statement of purpose did not contain all information required under the Regulations. The inspectors reviewed the centre's statement of purpose and found that it was now subject to regular review and had been updated to contain all information required under Schedule 1 of the Regulations and reflected the services and facilities provided.

Furthermore, the statement of purpose was available to residents in an accessible
Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that the provider's management systems did not effectively monitor the service to ensure a consistent and good quality of service for all residents in the centre and to ensure that the centre was in compliance with regulatory requirements. In addition, the provider had not monitored the implementation of actions in the provider's own plan since the previous inspection or ensured the effectiveness of those actions.

Inspectors met with the person in charge during the course of the inspection. Inspectors found that the management systems to monitor the care and support needs of residents, the delivery of quality services and the review and implementation of action plans as required were ineffective. On-going non-compliance remained that had not been identified by management of the centre. This included:
- no audits of financial management throughout the centre, to ensure consistent methods were maintained in-line with policies
- no medication audits identified, gaps in practice such as, documentation, labelling and inappropriate storage facilities
- Management did not identify that assessments for self administration were not completed in all areas of this centre
- failure to identify that three concerns of abuse were recorded but no investigation had been completed
- failure to identify bathroom facilities in two houses required improvement
- no plan in place following outcomes of compatibility assessments completed.

On the day's of inspection, inspectors found that additional staffing to assist at management level had been introduced. However, inspectors found that this had not improved the overall governance arrangements. There continued to be gaps in practice
and evidence of poor oversight of all houses in the centre. In addition, there was no coordinated approach by all managers working in the centre, to ensure that all non-compliance was addressed satisfactorily.

**Judgment:**
Non Compliant - Major

**Outcome 15: Absence of the person in charge**
*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The centre had suitable arrangements in place in the event of the person in charge's being absent for over 28 days.

The person in charge confirmed their understanding of the requirement under regulation to inform the Health Information and Quality Authority (HIQA) of absences over 28 days.

The inspector found that staff were aware of management arrangements to be put in place in the absence of the person in charge, which were further reflected in the centre's statement of purpose.

**Judgment:**
Compliant

**Outcome 16: Use of Resources**
*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**
Use of Resources

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
Services and facilities provided at the centre reflected the statement of purpose and resident’s assessed needs.

Staffing arrangements ensured that residents were supported in-line with their assessed needs as reflected in personal plans and risks assessments on both a group and one-to-one basis by staff. The inspectors found residents were supported to achieve their personal goals and planned weekly activities which were further reflected in discussion in discussions with staff and records reviewed during the inspection.

Although close to local amenities such as shops and cafes, residents at the centre were further supported through access to vehicles, wheelchair taxis and local bus services.

Judgment:
Compliant

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:
Staffing arrangements in place at the centre reflected residents' assessed needs. However, further improvement was required to staff files and training provided in the centre.

The person in charge had not ensured that both an actual and planned roster was in place. Inspectors found that there were two copies of a roster in place in one house, which were not completed by the person in charge. The person in charge was also unaware of changes that had occurred.

Inspectors found that staffing arrangements reflected residents' assessed needs as described in their personal plans and risk assessments. Furthermore more, staffing arrangements ensured that both residents' health and social care needs were addressed in a timely manner by suitably trained staff. In addition some residents, due to their age, had chosen to retire from day services or not attend their placement every day of the week and staffing arrangements had been put in place by the person in charge to
accommodate this choice and were reflected in the roster.

Throughout the inspection, residents received support in a timely and respectful manner. Where able to, residents told the inspector that they liked living at the centre and got to do activities of their choice which was further reflected in discussions with staff and activity and goal records.

Staff told the inspector that they felt supported by the management team and attended regular monthly team meetings. Furthermore, staff had completed an annual personal development plan with either the person in charge, clinical nurse manager or director of nursing, which looked at their roles and responsibilities and future training needs.

The previous inspection had found that staff training records were incomplete and did not clearly show whether staff had received up-to-date training. The inspector reviewed records maintained by the person in charge and found that staff had access to both mandatory and centre-specific training, which related to residents' assessed needs. However, improvement was required as training provided in medication management did not include a competency assessment to ensure that all staff were informed and aware of practice required in the centre.

The inspector reviewed a sample of staff personnel files and found that they did not contain all documents required under schedule 2 of the regulations such as full employment histories and copies of garda vetting disclosures.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Use of Information

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

**Findings:**
The inspector found that the provider and person in charge maintained all records required under the regulations.
The inspector found that the provider and person in charge maintained up-to-date records which related to residents as required under Schedule 3 of the regulations such as a directory of residents, healthcare records and incidents and accident reports.

The provider ensured that a copy of the statement of purpose and all notifications submitted to the Health Information and Quality Authority were available at the centre. In addition, records such as residents' written agreements and records of food provided at the centre were maintained as required under Schedule 4 of the regulations.

The inspector reviewed the provider's policies and procedures and found that all policies required under Schedule 5 of the regulations were not in place and reviewed in-line with regulatory timeframes. For example, there was no policy in place for the recruitment and retention of staff in the centre, at the time of inspection.

The provider had ensured that an up-to-date insurance policy against accidents or injury to residents, staff and visitors was in place for the centre.

**Judgment:**
Substantially Compliant

**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:**

Catherine Glynn  
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 Health Service Executive</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004431</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>13 &amp; 14 December 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>05 January 2018</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 01: Residents Rights, Dignity and Consultation**

**Theme:** Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that all outcomes of all complaints were recorded and the satisfaction of the complainant documented.

1. **Action Required:**
   Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
All complaints have been reviewed across the five houses under Oxview Services and the satisfaction/ dissatisfaction documented in relation to each complaint. All efforts made to remove any element of dissatisfaction will be fully documented. In addition Consumer satisfaction document has been introduced which will assist in the close out of future complaints within the Service.

A complaints audit has been completed by the management team across the service

Proposed Timescale: 04/01/2018

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that the written agreement was up-to-date when residents move houses in the centre.

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:
All written agreements for individual residents have been reviewed across the service and fully updated where required, completed on the 18/12/2017 and validated by the PIC

Proposed Timescale: 18/12/2017

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that all written agreements and the accessible version, had the correct charges listed.

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:
All written agreements have been reviewed and the correct charges listed.

Written agreements are available to all individual residents of the service in accessible format. Reviewed and Validated by PIC.

Proposed Timescale: 18/12/2017

<table>
<thead>
<tr>
<th>Outcome 06: Safe and suitable premises</th>
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<tr>
<td>Theme: Effective Services</td>
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</table>

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider had not ensure that facilities in all bathrooms were reviewed, assessed and provided in-line with the assessed needs of residents:

- one bathroom required space to enable movement for staff to support residents who had mobility needs
- no hand basin was provided in another bathroom
- no splashguards were in place and no measures in place to prevent slips, trips or falls in bathrooms
- no review by MDT regarding facilities in place.

4. 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:
• Multi Disciplinary Team meeting including Physio, OT, Maintenance Foreman, PIC and core staff reviewed and assessed bathroom facilities. An improvement plans to address the concerns was completed: 02/01/2018
• A plan is in place to install level access shower & handbasin in the ensuite/bedroom area. Additional space will be made available in the main bathroom to enable movement for staff to support residents who have mobility issues/requirements. – Expected date of completion 28/02/2018
• Splashguard ordered – due for Installation 28/02/2018

Proposed Timescale: 28/02/2018

<table>
<thead>
<tr>
<th>Outcome 07: Health and Safety and Risk Management</th>
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<td>Theme: Effective Services</td>
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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

- one bathroom required space to enable movement for staff to support residents who had mobility needs
- no hand basin was provided in another bathroom
- no splashguards were in place and no measures in place to prevent slips, trips or falls in bathrooms
- no review by MDT regarding facilities in place.
requirement in the following respect:
The provider failed to identify risks associated with bathroom facilities provided in the centre. Furthermore, the local safety statement did not identify the premises issues found by inspectors.

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

Please state the actions you have taken or are planning to take:
Risk assessment has been completed to capture risks associated with bathroom facilities. Completed on the 22/12/2017 by Clinical Nurse Manager. All risks are now managed in line with the risk assessment and continue to be managed as per identified careplan and nursing intervention to support the resident/s when utilising the bathroom facilities.

The Local safety statement has been updated by the DON to reflect these risks as of the 03/01/2018.

Proposed Timescale: Completed 22/12/2017 & 03/01/2018

Proposed Timescale: 03/01/2018
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that there were adequate access to hand washing facilities in all houses in the centre.

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

Please state the actions you have taken or are planning to take:
• Plan in place to install additional handbasin (28/02/2018)
• Hand gels are in place and available in all bathrooms

Proposed Timescale: 28/02/2018

Outcome 08: Safeguarding and Safety
Theme: Safe Services
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that each resident was supported and educated to protect themselves and report all concerns when evident.

7. Action Required:
Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Please state the actions you have taken or are planning to take:
- Safeguarding is a standing agenda item at both resident & staff meetings. Safeguarding is discussed with all residents at the weekly resident meetings across the service and on a one to one basis if required.
- The Social worker assigned to the service provides additional support and attends residents meeting periodically to discuss any areas of concern.
- Psychological support has been provided by the LDS Psychologist with regard to concerns raised by resident/s.
- One to one meetings have been facilitated by the psychologist and individual resident where required.
- Advocacy support has been requested by re-referral to the local Advocacy service.
- Notifications of Abuse continue to be managed through incident recording (NIMS), Safeguarding and through the Regulatory process.

Proposed Timescale: 20/12/2017

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that all residents were safe and supported in the centre and all safeguarding concerns were investigated inline with organisational policy.

8. 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 incidents of alleged abuse have been identified and fully investigated in line with HSE policy validated by the management team to include the PIC, A/DON/DON/Provider Nominee.

A management team meeting was held on the 13/12/2017 regarding any future concerns, accusations, allegations of abuse raised by residents. There will be full adherence to the Safeguarding Policy, Complaints Policy and Trust in Care Policy going forward. Relevant notifications will be submitted as appropriate. Staff members fully informed regarding these requirements by the PIC/ADON, DON by the 18/12/2017.

Two staff members of the Oxview Team have recently completed Designated Officer
training and this will further strengthen Safeguarding across the service. This training was completed on the 29/11/2017. Designated Officer visits continue across the service on a weekly basis.

**Proposed Timescale:** 18/12/2017

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge had failed to identify, record and investigate all concerns as required, in a timely manner.

**9. 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 has carried out a review of all concerns / incidents across the service for Quarter 4 2017.

As a result of this review one resident was met on the 14/12/2017 regarding recent accusations/allegations made on his part. These were discussed in a collective manner by the PIC and Designated Officer with the resident. Reassurance and support was offered to the resident and a full investigation was conducted in relation to the concerns raised with a satisfactory outcome for the resident.

Investigation report/findings submitted to the Regulator on the 15/12/2017

A muti disciplinary team meeting was held to support this resident on the 21/12/2017 and a further review meeting has been scheduled.

**Proposed Timescale:** 21/12/2017

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge had failed to ensure that new staff were trained and educated in-line with local policy regarding management of safeguarding incidents.

**10. 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:
Safeguarding training has been completed for all staff across the Oxview Service Staff.

Proposed Timescale: 04/01/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge did not notify HIQA when a resident was admitted to hospital for management of a seizure.

11. Action Required:
Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Please state the actions you have taken or are planning to take:
The PIC has completed and submitted the appropriate documentation, NFO3, to the Regulator on the 14/12/2017. Documentation concerning a 20 day follow up report has been submitted to the Regulator on the 31/12/2017.

All future notifications will be submitted in line with the identified time frame and all staff are fully aware of the statutory notifications.

Proposed Timescale: 31/12/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to notify and identify an incident of suspected abuse and submit it to HIQA within required timeframes.

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

Please state the actions you have taken or are planning to take:
The Person in Charge has reviewed the incident of suspected abuse.

In particular, one resident was met on the 14/12/2017 regarding recent accusations/allegations made on his part, these were discussed in a collective manner by the PIC and DO with the resident. Reassurance and support was offered to the
resident and a full investigation was conducted in relation to the concerns raised with a satisfactory outcome for the resident.

The PIC will ensure all future notifications will be submitted in line with the identified timelines.

A management team meeting was held on the 13/12/2017 regarding any future concerns, accusations, allegations of abuse raised by residents. There will be full adherence to the Safeguarding Policy, Complaints Policy and Trust in Care Policy going forward. Relevant notifications will be submitted as appropriate. Staff members fully informed regarding these requirements by the PIC, A/DON, DON by the 18/12/2017.

**Proposed Timescale:** 20/12/2017

### 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:**
The person in charge had not ensured that all medication storage was maintained in-line with local policy. For example, inspectors found that medication was being stored in unlocked cupboards, that some medication was mislabelled and that stock control measures had not identified missing medication in the centre.

**13. Action Required:**
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
- Additional secure medication storage space has been made available to the centre. Completed 02/01/2018.
- Mislabeled Medication was returned to the Community Pharmacist and has been replaced with new medication stock. Completed 15/12/2017
- Stock control measures have been reviewed by the PIC and the Pharmacist and changed from monthly to daily recording as appropriate. Completed 16/12/2017
- A full investigation has been completed by the PIC supported by the Clinical Nurse Manager, Quality, Risk & Service User Safety regarding the recent medication error, recommendations as follows:
  - Complete Medication Management Policy on HSE Land – Staff Nurses
  - Revisit and continue appraisal on a monthly basis for three monthly period regarding medication error.
- Review of Behaviour Support Plan
- Medication Audit undertaken by the CNM – 03/01/2018
- Medication Audit will be undertaken by Pharmacist – 11/01/2018

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<th>Proposed Timescale: 11/01/2018</th>
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<tr>
<td>Theme: Health and Development</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge had failed to identify gaps in documentation records and address these gaps.

**14. Action Required:**
Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

**Please state the actions you have taken or are planning to take:**
A full review of practices in relation to medication management has been completed by the PIC and the Pharmacist

A full investigation has been completed in relation to a recent medication error identified in one house. Investigation completed on the 19/12/17 and report finalised on the 20/12/17. Report forwarded to the Regulator.

All staff nurses across Oxview services to complete medication management training on HSE land by 15/01/18.

The CNM 1 completed a medication audit on the 03/01/2018.

The Community Pharmacist will complete a full medication Audit for one house on the 11/01/2018

Stock control measures have been reviewed and changed from monthly to daily recording as appropriate.

A Medication Audit Schedule has been devised for the service and will be completed on a monthly basis by management.

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<tr>
<td>Theme: Health and Development</td>
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</table>
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not completed assessments on each resident's capacity to self-administer their medication.

15. **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:
Self Administration of Medication Assessment has been undertaken by the PIC for all residents and reflects risk associated with self-administration of medication.

**Proposed Timescale:** 20/12/2017

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**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 provider had failed to ensure that a clearly defined management structure was in place at the centre, with clear lines of responsibilities and accountability.

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

Please state the actions you have taken or are planning to take:
The management structure for the service is now clearly defined and is identified in the updated Statement of Purpose.

The PIC has overall responsibility for the designated centre. Management and governance has been further strengthened by the appointment of a new Director of Nursing since 6th November 2017. Two PPIM’s have been introduced to the service with specific responsibility for two areas of the service.

The position of Assistant Director of Nursing for Cloonamahon Services continues to be covered in an acting capacity. The A/DON provides further management support to Oxview services.

**Proposed Timescale:** 05/01/2018
**Theme:** Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management systems in place at the centre had not ensured the safety and well-being of all residents in the centre.

17. **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 management structure for the service is now clearly defined and is identified in the updated Statement of Purpose.

The PIC has overall responsibility for the designated centre. Management and governance has been further strengthened by the appointment of a new Director of Nursing since 6th November 2017. Two PPIM’s have been introduced to the service with specific responsibility for two areas of the service.

The position of Assistant Director of Nursing for Cloonamahon Services continues to be covered in an acting capacity the A/DON provides further management support to Oxview services.

Two staff members of the Oxview Team have completed Designated Officer training on the 29/11/2017 and this will further strengthen Safeguarding across the service.

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**Proposed Timescale:** 29/11/2017

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to review and ensure that all information required by schedule 2 was maintained.

18. **Action Required:**
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
A full review has taken place for all staff files completed by the PIC, A/DON and the Administration team, Cloonamahon Services. Information gaps identified have addressed and information is now available on all files.
Awaiting outstanding Garda Vetting Disclosures for all Ox View Staff, this has been requested from the Data Controller by the Provider.

**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:**
The person in charge had failed to ensure that all staff trained in medication management were competent and effective in the administration of all medication. In addition, that staff were not familiar with all the requirements of local policy.

19. **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 PPIM has developed a schedule to monitor medication management compliance and has commenced the competency process with all relevant health care staff.

**Proposed Timescale:** 15/01/2018

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The provider failed to ensure that the policy on the recruitment, retention and garda vetting of staff was available in the centre.

20. **Action Required:**
Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

**Please state the actions you have taken or are planning to take:**
A local guideline is now available specific to the local recruitment/retention process. This guideline is available across the service and located in the Schedule 5 policy folder.

A Standard Operating Procedure is available to support the management of Garda Vetting with local HSE Services and is available on site and located in the Schedule 5 policy folder.
**Proposed Timescale:** 28/12/2017