

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by CoAction West Cork Ltd
<b>Centre ID:</b>	OSV-0002105
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	CoAction West Cork Ltd
<b>Provider Nominee:</b>	Denise Cronin
<b>Lead inspector:</b>	Mary O'Mahony
<b>Support inspector(s):</b>	Marie Scally;
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	17
<b>Number of vacancies on the date of inspection:</b>	0

## **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 monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 15 April 2015 09:00 To: 15 April 2015 20:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This follow up monitoring inspection of the designated centre for adults with disability, by the Health Information and Quality Authority (HIQA or the Authority), was announced. As part of the inspection inspectors met with residents, the person in charge, management personnel, social care leaders and social care workers. Inspectors reviewed the policies and procedures and examined documentation which covered issues such as staff files, complaints and incidents, personal plans, and health and safety risk management. The person in charge informed inspectors that she was in the position of person in charge for one year. She stated that she had recently been appointed to the position of provider also. As the provider she was responsible for centres in two other areas in West Cork and said that the organisation was intending to develop another centre also in the region. The provider outlined plans to appoint a new person in charge to this designated centre. During the inspection there were fifteen residents in the centre, which was comprised of five houses located within a two mile radius of each other.

The facilities and services in each of the five houses varied:

House 1: provided a seven day residential service: three full time residents lived in this house and there was one respite bed available.

House 2: provided a four day respite service: there were three regular residents in this house and one night was shared between three respite residents.

House 3: provided a seven day residential service: three full time residents lived there, one resident stayed from Monday to Friday and two respite residents shared the week between them.

House 4: provided a respite service from Monday to Friday for three regular residents: sometimes a planned respite resident would replace a regular resident.

House 5: this house was currently vacant.

Inspectors met with a number of residents during the inspection. The houses were located a short distance from the local town. They were spacious and generally well maintained. The furniture and fittings were found to be of good quality and most of the premises were suitable for the needs of residents. The action plan at the end of the report identifies areas where improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities 2013. Improvements were required in the areas of staff training, fire safety management, medication management and health and safety risk assessments.

Due to the serious failings in fire safety management identified on the previous inspection an immediate action plan had been issued to the provider. In response to this immediate action plan, the provider had given assurance to the Authority that suitable provision of effective fire safety management systems were in place. However, during this inspection the provider was again issued with an immediate action plan for continued non compliance in relation to effective fire safety management systems. Satisfactory responses and assurances were not received by the Authority within the required time frame in the area of fire safety. The action plan response was rejected and the provider was asked to forward the fire safety report which they had commissioned, to the Authority. The provider stated the funding will be required to carry out the alterations and improvements required in this report. A copy of the report was received by the Authority on 14 August 2015. These issues will be further discussed in the 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):**

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

**Findings:**

Actions not completed since the previous inspection:

The nominated person had not maintained complete details of any investigation into a complaint, the outcome of a complaint, any action taken in response to a complaint and whether or not the resident or complainant was satisfied.

During this follow up inspection, inspectors noted that the rights of residents were supported by staff. Residents were treated with dignity and there was a regular consultation process in place. One resident informed inspectors that she was a member of the advocacy group for the organisation and she was also facilitated to attend national fora on issues which impacted on the residential disability sector. A house meeting was held weekly and inspectors saw minutes of these meetings. This resident had been informed about the impending inspection and said she was reassured by inspectors as to why this sector was subject to inspection and regulation. She was also familiar with relevant national developments in other designated centres.

Inspectors observed staff interacting with residents in a respectful manner. They were seen consulting with residents on various issues and feedback was taken into account when planning menus and weekend events. A folder containing accessible documents was displayed in the houses. This included information on how to make a complaint, residents' rights, advocacy, communication and the resident's guide. There was pictorial input in most of the documents.

Residents were involved in developing their personal plans. Residents could make choices about their daily lives such as evening routine, the food shopping list and what interests they wanted to pursue. Staffing was arranged in a manner to support residents with their individual interests and preferences and there was continuity of staff members. The provider had developed a number of policies to provide guidance to staff on the care of residents' property and finances, as required by the Regulations.

Residents were enabled to do their own laundry if they wished. Residents maintained control over their personal possessions. However, the provider failed to ensure that each resident availing of services in the centre had adequate space to store and maintain his or her clothes and personal property and possessions. This was significant where residents who required respite would use the bedroom of a full time or regular resident at weekends and sometimes during the week. Inspectors observed that there were no locked facilities available for residents to store their belongings in this situation in the interest of their privacy and dignity.

Individual records were kept of the weekly spending money for each resident. Inspectors reviewed a number of these and noted transactions were being signed by two staff members and the resident where possible. The amounts checked correlated with the balance in the written record. However, there were inadequate safeguarding practices in relation to the management of resident's finances. Following conversation with the person in charge/provider and the financial controller inspectors understood that residents would be required to contribute towards the cost of a staff member to accompany them on overnight stays and concerts. Inspectors viewed records which confirmed this. These records indicated that residents attended events such as concerts and seasonal pantomimes. Inspectors saw that some residents had been on a Christmas shopping trip to Dublin and noted that the residents involved had paid for accommodation for the staff who accompanied them.

Residents were supported to ensure their involvement with the local community. This included the use of local amenities such as the cinema, library, shopping centres, and hairdressing facilities. Some residents engaged in work experience and the person in charge said that the community provided excellent support to residents by providing work experience opportunities. Residents were facilitated to go for walks and to take part in educational courses suitable to their abilities. The person in charge/provider informed inspectors that residents were assessed individually to attend the day care centre or the 'outline' men's-club group and the recreational therapy (RT) group.

There was a complaints policy in place. However, the policy seen by inspectors was dated 2009. Nevertheless, the person in charge showed inspectors the new draft policy. An easy-to-read version of the complaints' protocol to be followed for residents was prominently displayed in the hallways. The Health Service Executive (HSE) complaints leaflet 'Your Service, Your Say' was available on notice boards. The centre had a dedicated complaints officer. Staff and residents were aware of the name of this person and how to initiate a complaint. However, records were not maintained in a complete and detailed manner. Inspectors noted that the satisfaction of the complainant and any improvement or learning which had occurred was not recorded for all complaints. The name of the complaints officer and independent appeals person for complaints was not identified in the complaints policy. The name of the independent appeals officer was not

identified on the complaints protocol displayed in the centre. The person in charge had been asked to address the complaints process on the previous inspection. A 'house issues' book had been developed since the last inspection and the provider/person in charge informed inspectors that this was used for residents to raise concerns within the houses. However, this had not been correlated with the complaints in the centre and the person identified as responsible for coordinating complaints had not been notified of the issues of concern recorded, which were actually complaints. Some complaints were computerised but were not easily accessible to inspectors or staff for the purposes of audit of complaints in individual houses.

Staff confirmed that residents were supported to exercise their political, civil and religious rights in line with their individual wishes and abilities. Examples of this were that residents were supported to attend religious ceremonies of their choice and other residents spoken with by inspectors were aware of their voting rights.

**Judgment:**

Non Compliant - Moderate

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

The action required from the previous inspection on 18 and 19 November 2014 was being progressed and the provider/person in charge had indicated in the action plan following that inspection that the completion date for this action was 30 September 2015

During this inspection each resident in the centre was facilitated to participate in activities appropriate to their preference and their abilities. Inspectors were informed by staff that residents were involved in daily chores and were involved in writing the shopping lists. Their likes and preferences were ascertained from their representatives, where necessary. Inspectors observed residents going out to the day centre. Inspectors also spent time with residents when they returned at tea time and saw that they were involved in kitchen tasks and preparing their meals. Inspectors observed staff talking with residents about the events of the day. Staff outlined the residents' routine for

relaxation in the house such as beauty therapy, listening to music, art and crafts as well as favourite TV programmes and films. All residents attended day care facilities on weekdays and some residents informed inspectors about their duties they performed as part of their work experience. The centre had its own minibus in which residents travelled to day care facilities. There was good communication between the houses in the centre. A staff member from each house accompanied residents to the activation centre in the morning to provide a care update to the day centre staff, depending on the abilities of those travelling.

Inspectors saw that the bedrooms were furnished with duvet covers, pictures, trophies and other personal items. However, in one house the rooms were not personalised as according to the provider/person in charge, the staff were constrained by the fact that the house was rented. This limited their freedom to improve décor in that house. Residents had not made use of the lockers and wardrobes and there were limited pictures on the walls. Residents' clothes were stored in their suitcases in some rooms. There were fire safety issues in one house which had previously been outlined to the provider/person in charge at the November inspection. This will be addressed under Outcome 7: Health and Safety and Risk Management. There were television sets and bedside lamps in some bedrooms, depending on the individual resident's needs. Inspectors were informed by staff of goals which had been reached by the residents with staff support.

The arrangements to meet each resident's assessed needs were outlined in a personal care plan (PCP). The person in charge showed inspectors these plans and it was evident that they had been drawn up in line with the specific assessed needs of residents. The plans had been personalised with residents' photographs and the person in charge informed inspectors that this ensured that residents were able to identify their file. 'Communication passports' were seen which were detailed and informative. The person in charge also said that 'medical passports' were now in use in the event that a resident had to go to hospital. Most of these had been developed since the last inspection. However, not all PCPs seen by inspectors contained the name of the key worker. The person in charge informed inspectors that this were being addressed. Inspectors viewed evidence that residents had access to the multidisciplinary team such as the dietician, the general practitioner (GP), physiotherapist, occupational therapist, dentist, social worker and the psychological services. However, inspectors observed that not all residents were re-accessed appropriately following a change of need. This was addressed under Outcome 11: Healthcare needs. There was evidence of consultation with family members or representatives. Inspectors saw evidence that where goals were set, flexibility was required, depending on needs of residents, at a particular time. There were photographs of staff members who were on duty, on the notice board, in the kitchen of each house. Personal plans were being reviewed as required by the Regulations.

**Judgment:**  
Compliant

**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:**

Findings:

Actions not completed since the previous inspection included:

~The controls required for the risks specified under Regulation 26 were not included in the risk management policy

~All hazards in the centre were not identified and controls were not in place to control or mitigate the risks presented

~The centre lacked effective fire safety management systems (A previous immediate action plan was issued by the Authority on this issue on the inspection of 18 and 19 November 2014)

During this inspection inspectors noted that the centre had a health and safety statement which was dated December 2014. It identified, assessed and outlined the controls required for certain risks in the centre. Procedures were in place for the prevention and control of infection. Alcohol hand gels, plastic aprons and disposable latex gloves were available. Staff had training in the suitable hand washing technique and there were Health Service Executive (HSE) leaflets in relation to hand hygiene on display. Housekeeping duties were carried out by the staff. There were coloured coded systems in use for cleaning and food preparation.

There was a washing machine and tumble dryer in each house and the equipment was in good repair. Inspectors noted that there was a sufficient supply of clean towels and bed linen in each house for all residents. However, it was not clear if each resident had an individual supply of towels. In addition, in one house a tumble drier was unsuitably stored on top of a work top and was unsecured. The centre had a risk management policy and a risk register. However, the risk management policy did not outline the controls in place for the risks specified under Regulation 26 (c). In addition, the risk register was not complete and was not accessible to all staff as the risk register was only available online. There was no policy on the prevention of self harm and this was particularly relevant as a resident had been identified as exhibiting self-harm behaviour.

Inspectors noted other risks in the centre had not been assessed such as unsafe objects, equipment and liquids stored in unsecured cupboards, the storage of latex gloves on bedside lockers, cleaning products stored in the bathroom, no bathroom or bedroom door keys for privacy and dignity of residents, unsafe outdoor equipment on a site and unsecured outdoor spaces for residents. Similar to findings on the previous inspection, inspectors noted that the outdoor paths and drive ways in some houses were broken and uneven in places. The potential trip hazards presented had not been identified or risk assessed. Repairs were not planned at the time of inspection. In addition, the upstairs window openings in all houses had not been risk assessed having been identified as potential hazards on the previous inspection. Some floor covering

required replacement. In one toilet a ceiling fan circular vent had not been put in place, since the previous inspection, even though the preparatory building work had been done. Not all toilets and shower areas had grab rails in place to support residents with mobility needs, in some houses. Furthermore, inspectors observed plastic chairs in use in some dining rooms for residents. The use and suitability of these chairs had not been risk assessed for specific residents.

One house in the designated centre was currently unoccupied. Inspectors observed that this house required extensive refurbishment before it could be occupied by residents. The provider stated that this house was owned by the service and said that residents would eventually transfer to this house from one of the rented houses. In this house inspectors noted that bathroom floor coverings were stained near the toilet and the mattress on one bed was heavily stained. The fire panel in this house was shared by the house next door and was located in a utility room which was in need of refurbishment.

A fire evacuation plan was in place in each house of the designated centre and in the event of an evacuation of the centre being necessary, alternative accommodation had been identified. Regular fire drill training was documented. Since the last inspection all residents had now been provided with personal evacuation plans (PEEPS). Records reviewed by inspectors indicated that the fire alarm was serviced on a quarterly basis, fire safety equipment was serviced on an annual basis. However, not all fire assembly points were identified. There was emergency lighting in place. While there was evidence that arrangements were in place for reviewing fire precautions which included the testing of fire equipment, inspectors remained seriously concerned about the lack of fire safety measures in other houses. For example, there was a lack of smoke detectors in house 4 as identified during the previous inspection. Inspectors noted open fires and stoves in some houses. The provider/person in charge stated that these fires were not used. However, any hazards associated with these had not been risk assessed. Furthermore, not all staff with whom inspectors spoke had been afforded the mandatory fire training. In addition, fire extinguishers were not affixed to the wall in one house but were stored free-standing in various areas: any additional risks associated with this arrangement had not been assessed. Nevertheless, carbon monoxide detectors had been installed. Fire drills were carried out regularly and inspectors saw evidence of this. However, the provider/person in charge stated that the fire panel for one house was still located in the adjoining house which was temporarily not in use. These two houses had previously been joined by a connecting upstairs hallway. However, inspectors found that the current location of the fire panel was not suitable to meet the fire safety needs of residents. In the event of the fire alarm sounding and due to the current location of the fire panel, staff would have to leave the occupied house to view the fire panel located in the unoccupied adjoining house. In addition, this unsuitable arrangement had not been risk assessed.

In one house the fire testing certificate on display was out of date. These fire safety non-compliances had warranted an immediate action plan on the inspection of 18 and 19 November 2014. However, in light of the above continuing failings a second immediate action plan was given to the person in charge/provider as regards the lack of suitable fire safety arrangements in the centre. The person in charge/provider had not provided a satisfactory response to the Authority as regards the provision of fire safety arrangements in the centre within the required timeframe as set by the Chief Inspector

on both occasions. Findings on this second inspection confirmed this. The provider was informed that this continued non compliance in relation to fire safety requirements was a serious breach of Regulations.

Staff had up to date moving and handling training, infection control and hand hygiene training. However, other aforementioned mandatory training, for example, positive behaviour support training, protection of vulnerable adults with disabilities and fire training was not all up to date and some staff did not have this provided. The provider/person in charge confirmed that updated skills in de-escalation techniques and behaviours that challenge had not been provided to staff. This will be addressed under Outcome 17: Workforce.

**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:**

Actions not satisfactorily implemented since the previous inspection included as follows:

- staff had not received training in the management and de-escalation of behaviour which challenges
- The policy on restrictive procedures did not follow the guidelines in national policy, in best evidence practice and in the centre's own policy.
- there was a lack of guidance available to staff to prevent an incident of peer abuse
- not all staff had received appropriate training in the safeguarding of residents and in the recognition, detection and response to abuse
- not all residents had individual intimate care plans in place to guide staff in this aspect of care.

During this inspection the person in charge/provider informed inspectors that she was involved in the management of the centre on a consistent basis and she had identified a staff member to act as deputy person in charge, due to the added requirements of her new role as provider and person in charge. She said she ensured the safety of residents in the centre by talking to residents, staff and speaking to their relatives and representatives. She informed inspectors that she met with staff regularly and that she

was aware of her obligation to report any allegation of abuse to the Authority. During the inspection staff were seen to act in a kind manner towards residents and included them when conversing with each other. Residents had been informed about the inspection and some residents spoke with inspectors. They informed inspectors that they felt safe in the centre and that their independence was encouraged. One resident told inspectors that she was an advocate for others who were non-verbal and she was aware of how to report her concerns or complaints. She attended advocacy meetings and having spoken with inspectors she undertook to explain the importance of the inspection process, in the protection of residents, at her next advocacy meeting.

Inspectors reviewed personal care plans for managing any behaviour escalations and saw that interventions were being implemented where required. There was a policy on 'behaviours which challenge'. However, this had not been updated since 2011. The centre availed of the services of behaviour experts such as psychologists and occupational therapists in the day care centre to support them in drawing up these plans. Residents and their representatives were involved in the personal care plans where appropriate. However, the majority of staff with whom inspectors spoke had not received updated training in positive behaviour support and de-escalation techniques. This was confirmed by the person in charge/provider.

There was a policy on the management of allegations of abuse which was updated in April 2013. There was a named person identified as the person responsible for investigating allegations and the responsibility to report any allegation to the Authority was documented. Inspectors spoke with staff who were knowledgeable of what constituted abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. There was a nominated person to manage any incidents, allegations or suspicions of abuse. Training records indicated that some staff had received training in the prevention of abuse however not all the staff had received updated training. In addition all residents did not have individual intimate care plans in place. Nevertheless, intimate care preference formed part of the assessment of each resident, which was recorded in the personal plans. There was a policy in the centre to support respite residents. However, inspectors noted that this policy and the admission policy did not contain guidance for staff in protecting all residents from peer abuse.

There was a policy on the use of restrictive interventions which outlined measures to promote a restraint free environment. This was last updated in October 2013. This policy stated that there was a 'physical interventions' committee in the centre. Not all residents requiring restraint had risk assessments in their personal plans and there was no documentation in place to indicate that staff were supervising residents, who required restraints, on a regular basis. There was a policy and suitable measures in place for the management of residents' finances. Records were maintained of financial transactions made by and on behalf of residents. Records reviewed by inspectors were seen to be in order. However, there were inadequate arrangements in relation to the management and safeguarding of large amounts of residents' money. Inspectors noted and discussed this matter with the provider/person in charge. Effective management and safeguarding measures were required to ensure that large sums of money belonging to residents, were suitably and securely stored, as appropriate to individual residents needs. Inspectors also observed that in some situations only one staff member had signed for financial transactions.

<p><b>Judgment:</b> Non Compliant - Major</p>

<p><b>Outcome 09: Notification of Incidents</b> <i>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</i></p>
<p><b>Theme:</b> Safe Services</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> A record of all incidents occurring in the designated centre was being maintained and these were being notified to the chief inspector as required. Quarterly reports were received in retrospect following the last inspection.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 11. Healthcare Needs</b> <i>Residents are supported on an individual basis to achieve and enjoy the best possible health.</i></p>
<p><b>Theme:</b> Health and Development</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> Residents had access to the GP services and appropriate therapies, such as, the dentist, the psychologist, the dietician, the occupational therapist (OT), pharmacist and the speech and language therapist (SALT). There was evidence that residents had availed of allied health care services and specialist consultants. Residents had assessments and plans of care in their PCPs from SALT and the dietician. Documentation seen by inspectors with regard to information from these reviews was detailed. However, inspectors noted that one resident who had a swallowing difficulty had not been assessed by SALT since July 2014 even though the GP had indicated that his medications should now be crushed before administration, due to a change in swallowing ability.</p> <p>Regular multidisciplinary input was evident in the personal care plans. Residents were included in these reviews and inspectors viewed the records of recent reviews which had</p>

taken place. Some residents had documented their end of life advanced care plans and the provider/person in charge informed inspectors that these records were kept in the day centre. Inspectors noted that residents had access to refreshments and snacks with a selection of drinks and fresh fruit. Residents, spoken with by inspectors, indicated that there was a choice available to them and that their individual likes and dislikes were taken into account. There was an emphasis on a healthy lifestyle and residents were encouraged to walk to town and to go for walks with staff after work. There was a 'food pyramid' poster on display in each kitchen. The person in charge/provider informed inspectors that a policy was being developed entitled 'enabling best health policy' which was to be implemented for residents. Inspectors saw a food choice folder with pictorial input to aid non verbal residents and this was seen in use when staff were supporting residents.

Staff informed inspectors that the level of support which individual residents required would vary. This was supported by information in the personal plans reviewed on inspection. Staff were knowledgeable about residents' health and social care needs and were observed to provide care as outlined in the personal plans. They gave detailed information to inspectors about each resident's needs and how these needs were met.

**Judgment:**

Substantially Compliant

**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:**

Actions not satisfactorily implemented since last inspection:

- not all residents had been risk assessed as to their suitability to self administer medications
- staff members administering medications had not included the time of administration of the medication
- drugs had been transcribed for a resident by a staff member
- not all drugs had the maximum 24hr PRN (when necessary) dose included on the prescription
- effective medication audits had not taken place as none of the practices outlined above had been identified
- staff who administered medication had not signed the medication administration chart in a manner that was in line with best practice guidelines and inspectors found that the practice was not in line with the instructions for staff in the centre's policy:
- staff did not have up to date training in medication management and the training they

had been given did not follow the training outcomes outlined in the medication policy for the centre

- medication errors were recorded on the computerised system however, as the aforementioned medication errors had not been identified as errors, they had not been recorded

- medication error form attached to the policy had not been used to record errors and errors had not been notified to the pharmacist as they were not identified as errors

In addition, during this follow up inspection, inspectors noted that there was a written policy in place relating to the ordering, prescribing, storing, administration and disposal of medications for the centre. However, inspectors spoke with staff and found that they were not familiar with the guidance and protocols as outlined in the policy. For example, staff in one house in the centre had transcribed medication for one resident. Inspectors found that the guidelines on transcribing medication, as set out by An Bord Altranais agus Cnaimhseachais na HEireann, which were also referenced in the centre's policy had not been adhered to. The transcribed medication was unsigned and not witnessed. In addition, the centre did not have a policy document on transcribing medications to guide this practice. The new medication policy dated 2015 was still in draft form.

During this inspection also there were numerous examples of unsafe medication practice, for example:

- some medication prescriptions were undated

- a prescription for medication had no time of administration indicated

- staff members administering medications had not included the time of administration of the medication

- drugs had been transcribed for a resident by a staff member

- not all drugs had the maximum 24hr PRN (when necessary) dose included on the prescription

- individual boxes of medications for example: combivent and fybrogel: were not labelled

- there was no discontinued date and signature on a medication despite it being completed since 4 April 2015

- the drug charts were often on two pages: the second page did not contain any identifying information for the resident

- allergies and sensitivities were not recorded for all residents

- a specific medication for seizures, usually stored in a foil wrapper to preserve its effectiveness, was stored in a blister pack with a group of other medications

- a resident was prescribed a medication which he was no longer receiving, this had not been discontinued

- actions from the previous inspection indicated that each resident would now have a separate PRN medication chart: this was not in place for all residents

- staff had administered drugs without indicating the dose of the drug administered

- not all unused medications had been disposed of safely: a psychotropic drug was still in stock even though the resident was no longer receiving this. Inspectors noted that the care plan in his PCP still indicated that this should be given and this had not been removed to indicate the changed medication regime.

- the action plan for the previous inspection indicated that each resident would now have an individual medication plan and that all staff would be familiar with safe medication practice by 28 February 2015. Inspectors found that this was not in place.

- effective medication audits had not taken place as none of the practices outlined above

had been identified

-staff who administered medication had not signed the medication administration chart in a manner that was in line with best practice guidelines and inspectors found that the practice was not in line with the instructions for staff in the centre's policy:

-staff did not have up to date training in medication management and the training they had been given did not follow the training outcomes outlined in the medication policy for the centre

-medication errors were recorded on the computerised system however, as the aforementioned medication errors had not been identified as errors, they had not been recorded

-medication error form attached to the policy had not been used to record errors and errors had not been notified to the pharmacist as they were not identified as errors

-there was no evidence that staff competence was evaluated following training

-there was no list of medications which could be crushed available from the pharmacy for staff reference as specified in An Bord Altranais agus Cnaimhseachais na HEireann, Guidelines on Medication Management 2007.

During this inspection there were no controlled medications in use. There were improvements in practice noted since the previous inspection for example: the drug keys were stored safely and medications were stored in a locked cupboard in all houses. Residents did not require their medications to be crushed at present. A medication fridge was in place. This was locked and the temperature of the fridge was seen to be recorded daily. There were a number of residents in the centre with epilepsy and some respite residents were prescribed emergency epilepsy medication. Staff with whom inspectors spoke were aware of how to administer this medication and had been trained in its use. However, inspectors formed a view that the training in medication management was inadequate and this issue was addressed under Outcome 17: Workforce. External audit of medication management, including PRN (as required) and psychotropic medications was done by the local pharmacists, one of whom the person in charge/provider said was very attentive to the centre. The provider/person in charge stated that only one pharmacist was willing to provide the centre with pre printed medication administration record sheets (MARS) which was based on the GPs prescription. These charts set out the time of administration and the dose of the drug to be administered and would eliminate the need for transcription or the use of hand written medication doses and would promote safer practice. In view of the findings of this inspection the provider/person in charge stated that she would approach the pharmacists for more support, as set out in the Regulations.

Following the previous inspection the person in charge and the provider had been asked to provide the Authority with a comprehensive plan for medication management within two days of the inspection. While a prompt response was received to this issue in November 2014, inspectors found during this inspection that the actions proposed had not been implemented, in the timeline set out by the person in charge and provider.

**Judgment:**

Non Compliant - Major

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in*



*the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

There was a statement of purpose date October 2014 however, it did not contain all of the information required in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres For persons (Children and Adults) with Disabilities) Regulations 2013:

For example:

- there was no reference in the statement of purpose to access to training, employment and education for residents
- the statement of purpose did not specify a description of all room sizes and function in the centre
- the governance and management structure in the centre had not been updated in light of changes to senior management staff
- an updated statement of purpose had not been submitted to the Authority as required

**Judgment:**

Non Compliant - Moderate

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The actions not satisfactorily implemented since the last inspection included:

- The service in the centre was not consistently and effectively monitored such as the lack of robust medication administration audit and the failure to action the findings of the infection control and health and safety audit which was carried out in July 2014.
- Unannounced 6 monthly visits by the provider or a nominated person and the

compilation of a report on the quality and safety of care, as required by the Regulations, had yet to commence in the centre.

During this inspection, there was a governance and management structure in place however, it was not in accordance with the structure outlined in the statement of purpose. The person in charge/provider informed inspectors that her post was full time and she had recently been appointed to the post of provider also. She stated that she was engaged in the governance, operational management and administration of the centre on a regular basis. Regular management meetings were held between the person in charge/ provider and staff. Staff were facilitated to discuss issues of safety and quality of care at team meetings which she stated that she attended. Audit of areas such as infection control and health and safety had taken place in 2014. However, inspectors noted that audit action plans had not been developed and many of the findings of these audits had not been addressed at the time of inspection. This was similar to findings on the previous inspection. In addition, medication management audits had not commenced, despite a written commitment given by the provider in the action plan submitted to the Authority in relation to the last inspection.

Staff and resident surveys were carried out previously but these had not occurred on a regular basis and the survey forms seen by inspectors were not dated. During the previous inspection of November 2014 the person in charge/provider informed inspectors that she had hoped to commence unannounced inspections just prior to the announcement of that inspection. However, inspectors noted that the bi-annual unannounced inspections of the centre, by the provider/person in charge as required by the Regulations, had yet to commence in a formal manner.

The person in charge/provider was qualified for the role and was experienced in the centre. Staff and residents were able to identify her as being the manager and staff told inspectors that she was supportive. The person in charge/provider demonstrated some knowledge of the legislation. However, she said that she was not yet fully apprised of all the Regulations as she had recently been appointed and was the provider for a number of centres. She had a commitment to ongoing professional development. Inspectors were informed that a new person in charge would be appointed in the near future.

**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:**

There had not been a situation where the person in charge was absent for 28 days or more since the previous inspection. Suitable deputising arrangements were in place for the management of the centre in the absence of the person in charge. However, the person in charge said that the centre was interviewing for a new person in charge, as she was now the provider also and would be responsible for four centres, over a wide geographical area.

**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:**

Actions not satisfactorily implemented since the previous inspection were as follows:

- photographic identification was missing in one file
- a curriculum vitae (CV) gap analysis had not been undertaken for another staff member for a gap in employment details.

During this follow up inspection a sample of staff files reviewed by inspectors generally complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. However, similar to findings on the previous inspection, photographic identification was missing in one file and a curriculum vitae (CV) gap analysis had not been undertaken for another staff member. In addition, job descriptions were not on file for the roles which staff fulfilled in the centre. Inspectors viewed the policy on staff recruitment and saw that staff had fulfilled the required vetting procedures. There was an induction policy and procedure in place.

Training records reviewed by inspectors indicated that staff had attended a range of training. However, not all staff had received mandatory and updated appropriate training required by the Regulations such as medication management to include specialist epilepsy training, managing challenging behaviour and abuse prevention training. All staff members had not received mandatory fire training. Staff supervision records were seen and inspectors saw that some staff appraisals had commenced.

Inspectors found that staff had a good understanding of the responsibilities of their role and of the needs of the residents. Staff with whom inspectors spoke were interested in residents and in their welfare and achievements and were found to be committed to the ethos of the centre. Residents were seen to be familiar and relaxed with the staff on duty during the inspection. Staff had access to the Health Act 2007, a copy of the relevant Regulations, and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

**Judgment:**

Non Compliant - Major

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

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

**Findings:**

Actions not satisfactorily implemented since the previous inspection were as follows:

- the policy on risk assessment had not been updated and fully implemented
- the medication policy was still in draft form and had yet to be rolled out to staff
- the protection of vulnerable adults did not provide guidance for staff on dealing with peer abuse

during this inspection, inspectors noted that most records and documentation in the centre were generally maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. A directory of residents was maintained in the centre and this contained all of the items required by the Regulations. A record of residents' assessments and copies of personal plan were available. Inspectors noted that a record of nursing and medical care provided to the resident including any treatment or intervention was maintained. Resident's files were found to be generally complete and were kept in an accurate manner and were mostly up to date. For example, a record was maintained of all referrals and the outcome of these. Records relating to communication needs, money or valuables, incidents, fire safety were stored securely and were easily retrievable. However, training records were not easily retrievable and complaints records were not maintained in a complete and comprehensive manner.

The policies required under Schedule 5 of the Regulations were in place such as: medication management, the prevention of abuse, approaches to challenging behaviour and the provision of information to residents, among others. However, not all policies were adopted and implemented in practice and had not been updated regularly as required. Examples of this were the medication policy and the risk management policy. The policy on the protection of vulnerable adults failed to instruct staff that any allegation of abuse, whether suspected or substantiated was to be reported to the Authority (HIQA) within a three day time period. In addition, the protection of vulnerable adults did not provide guidance for staff on dealing with peer abuse. Furthermore, none of the policies seen were centre specific. Inspectors found that not all records were maintained in the centre as required under Schedule 3 and 4 of the Regulations, such as, a record of medication errors, the records required under Schedule 3 (h) and the records required under Schedule 4 (6).

**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:***

Mary O'Mahony  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by CoAction West Cork Ltd
<b>Centre ID:</b>	OSV-0002105
<b>Date of Inspection:</b>	15 April 2015
<b>Date of response:</b>	16 June 2015

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

The provider failed to ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions. This was significant where residents who required respite stay would use the bedroom of a full time or regular resident at weekends and sometimes during the week. Inspectors observed that there were no locked facilities available for residents to store their belongings in the

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

interest of privacy and dignity.

**Action Required:**

Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.

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

The rooms of our residents who are full time (seven days a week) are not used for respite.

We provide closet or drawer space for people on respite.

We are consulting with people regarding lockable space in the rooms they use.

This consultation is being documented.

If people would like to leave personal possessions safely in the room we are providing lockable space for them to do this.

**Proposed Timescale:** 30/09/2015

**Theme:** Individualised Supports and Care

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

The provider failed to insure that support was provided to residents to manage their financial affairs in a safe manner. For example, inspectors noted that resident's contributed towards staff to accompany them to outings and on holidays.

**Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

The organisation endeavours to support people who use our services to participate in social activities, including holiday events within available resources. The organisation pays staff to accompany individuals on planned holidays as per the policy 'Policy on People who use the services' Holidays' the organisation pays subsistence for staff who accompany individuals on holiday. However, it is the responsibility of the individual going on holiday to fund the travel and accommodation of staff who are there to support them on their holiday.

If staff support individuals to go out for a meal, the money the organisation pays towards the staff food in the housekeeping is used to pay for the staff meal. There are rules regarding the amount staff can spend, these are called subsistence rates. If the staff meal is more than the subsistence rate then staff have to pay the balance themselves.

The organisation also has a policy for Personal Money and Property, which outlines the supports in place for residents in managing their own monies. There is also a Group Home finances Policy.

The organisation will review all these relevant policies to ensure compliance with the regulations.

**Proposed Timescale:** 30/09/2015

**Theme:** Individualised Supports and Care

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

The provider failed to ensure that an effective complaints procedure for residents which included the name of the appeals person was in place.

**Action Required:**

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

The complaints policy needs to identify complaints officer and all others who are identified on the complaints poster. The policy has been amended and the complaints poster has been added as an appendix to the policy. All complaints pertinent to a designated centre are kept or accessible to the designated centre. Permissions for the PIC and Provider nominee on XVEA in order to access complaints for the designated centre.

A Designated Person has been identified in the policy now.

The local issues/concerns have now been included in the policy and there is a process of review of same by firstly the PIC of the designated centre quarterly and the complaints officer yearly.

Once the policy is amended in full it will be reviewed by the policy review group and then go for approval to the Board.

**Proposed Timescale:** 30/09/2015

**Theme:** Individualised Supports and Care

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

The provider failed to ensure that records were available which indicated that complainants were informed promptly of the outcome of their complaints and details of the appeals process.

**Action Required:**

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

We are including the house issues book as part of the complaints policy, this is an informal and local point for residents to raise a concern in the Residential Houses. The house issues book outlines the issue, the actions required, the outcome and the level of satisfaction of the complainant.

Within the Complaints policy there is a detailed outline of the timeframe for formal



complaints. Any amendments to the complaints policy will have to go to the Board for approval.

**Proposed Timescale:** 30/09/2015

### **Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

The risk management policy had not identified or risk assessed all hazards in the centre.

- latex gloves and chemicals not secure
- unsafe outdoor areas, such as unfinished uneven paths which presented a trip hazard
- no side gate on some houses with unsecured entrance to and exit from garden areas
- no locks on furniture with a risk to privacy and dignity not assessed
- the use of plastic chairs for some residents
- floor repairs
- grab rails not in place
- upstairs windows not restricted
- a external air vent/fan not in place in a toilet where preparatory work had been done for this
- unsafe location of a tumble drier

**Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

We are in the process of adopting a new Risk Management policy which is in line with regulatory requirements.

We rolled out training on June 03 2015 to frontline staff to facilitate the implementation of this policy.

We are working to a timeframe of four months to fully implement this policy in our residential houses.

By the end of the period each designated centre will have a risk register in place for the premises and the individuals being supported.

**Proposed Timescale:** 16/10/2015

**Theme:** Effective Services

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

The risk management policy did not contain the measures and actions in place to control the risks identified.

**Action Required:**

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management

policy includes the measures and actions in place to control the risks identified.

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

The new risk management policy has a risk management plan to outline the plans in place to control the risk.

We rolled out training on June 03 2015 to frontline staff to facilitate the implementation of this policy.

We are working to a timeframe of four months to fully implement this policy in our residential houses.

By the end of the period each designated centre will have a risk register in place for the premises and the individuals being supported.

**Proposed Timescale:** 16/10/2015

**Theme:** Effective Services

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

The risk management policy did not include the measures and actions in place to control the unexplained absence of a resident.

**Action Required:**

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

The new risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

The current policy Guidelines for absconding adults is a current control for this risk.

We rolled out training on June 03 2015 to frontline staff to facilitate the implementation of this policy.

We are working to a timeframe of four months to fully implement this policy in our residential houses.

By the end of the period each designated centre will have a risk register in place for the premises and the individuals being supported.

**Proposed Timescale:** 16/10/2015

**Theme:** Effective Services

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

The risk management policy did not include the measures and actions in place to control accidental injury to residents, visitors or staff.

**Action Required:**

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

The new risk management policy includes the measures and actions in place to control accidental injury to residents, staff and visitors.

We rolled out training on June 03 2015 to frontline staff to facilitate the implementation of this policy.

We are working to a timeframe of four months to fully implement this policy in our residential houses.

By the end of the period each designated centre will have a risk register in place for the premises and the individuals being supported.

**Proposed Timescale:** 16/10/2015

**Theme:** Effective Services

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

The risk management policy did not include the measures and actions in place to control aggression and violence.

**Action Required:**

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

The new risk management policy includes the measures and actions in place to control aggression and violence.

We are in the process of adopting a new Risk Management policy which is in line with regulatory requirements.

We rolled out training on June 03 2015 to frontline staff to facilitate the implementation of this policy.

We are working to a timeframe of four months to fully implement this policy in our residential houses.

By the end of the period each designated centre will have a risk register in place for the premises and the individuals being supported.

**Proposed Timescale:** 16/10/2015

**Theme:** Effective Services

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

The risk management policy did not include the measures and actions in place to control self-harm.

**Action Required:**

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

The new risk management policy includes the measures and actions in place to control self-harm.

We are in the process of adopting a new Risk Management policy which is in line with regulatory requirements.

We rolled out training on June 03 2015 to frontline staff to facilitate the implementation of this policy.

We are working to a timeframe of four months to fully implement this policy in our residential houses.

By the end of the period each designated centre will have a risk register in place for the premises and the individuals being supported.

**Proposed Timescale:** 16/10/2015

**Theme:** Effective Services

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

The provider had failed to ensure that systems were in place in the designated centre for the assessment, management and ongoing review of risk:

For example the risk register was not available in each house and was not complete.

**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:**

We are in the process of adopting a new Risk Management policy which is in line with regulatory requirements.

We rolled out training on June 03 2015 to frontline staff to facilitate the implementation of this policy.

We are working to a timeframe of four months to fully implement this policy in our residential houses.

By the end of the period each designated centre will have a risk register in place for the premises and the individuals being supported.

**Proposed Timescale:** 16/10/2015

**Theme:** Effective Services

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

The provider had failed to ensure that residents who may be at risk of a healthcare associated infection were protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

-some houses were visibly unclean

-the mop system was not in keeping with best practice for infection control: some mops were visibly worn and other mops were stored outside the back door.

-there was no protocol in place for infection control cleaning processes where up to three residents would share a room on alternate nights, for respite admissions

-there were areas of then houses which were visibly unclean

-a stained mattress and toilet floor covering was seen in one house

**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:**

One house is unoccupied and before it is used it will require works carried out to ensure it is fit for purpose. The mattress in question was removed and disposed of from the unoccupied house.

The house is still unoccupied and requires input from new residents before works can be carried out.

The other house has been cleaned and our housekeeping policy is being updated to ensure standards are maintained with regard to cleanliness.

All mops are now fit for purpose and being stored appropriately.

There is now a protocol in place for the turnover of respite rooms to ensure infection control cleaning processes are in place, this is documented.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

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

The provider had not put in place effective fire safety management systems. For example a competent, suitably qualified person had not indicated that the houses in the centre were in compliance with fire safety legislation.

**Action Required:**

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

As part of an immediate action we have engaged a firm to carry out fire compliance assessments, they are in the process of outlining works needed and the costings for same. We will have to consult with the HSE regarding funding for these works and engage in a tendering process.

This plan by the organisation has been documented and the Fire compliance risk assessments carried out, these have been sent to the Authority.

**Proposed Timescale:** 25/03/2016

**Theme:** Effective Services

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

The provider had not made adequate arrangements for reviewing fire precautions as

the findings of non compliance on this inspection were similar to the findings on the inspection of 18 and 19 November 2014 which resulted in a similar immediate action plan being issued by the Authority.

**Action Required:**

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

There are fire registers in each house kept up to date by the staff working in the houses and also maintained by the contractor assigned to test fire detection systems which are in three of the houses and the fire equipment in all of the houses, fire detection systems and panels are tested and maintained quarterly. Fire equipment is checked yearly by the contractor.

As part of an immediate action we have engaged a firm to carry out fire compliance assessments, they are in the process of outlining works needed and the costings for same.

We will have to consult with the HSE regarding funding for these works and engage in a tendering process.

Outline actions taken and evidence of same.

Regarding immediate actions, on the 16/04/2015 photographic evidence was sent to the Authority of actions carried out in two houses.

The commencement certificates for the splitting of a fire panel between two houses and updating of the system were sent to the Authority.

The organisations plan regarding fire compliance was sent to the authority on 08/05/2015. We have engaged a firm to carry out fire compliance assessments, they are in the process of outlining works needed and the costings for same. We will have to consult with the HSE regarding funding for these works and engage in a tendering process.

**Proposed Timescale:** 25/03/2016

**Theme:** Effective Services

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

The provider had not made adequate arrangements for detecting, containing and extinguishing fires.

For example, similar to findings on the previous inspections adequate and sufficient smoke detectors were not in place in the centre.

**Action Required:**

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

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

Extra smoke detectors were put in place on 16/04/2015 and photographic evidence sent to the Authority.

The organisations plan regarding fire compliance was sent to the authority on 08/05/2015.

We have engaged a firm to carry out fire compliance assessments, they are in the process of outlining works needed and the costings for same.

We will have to consult with the HSE regarding funding for these works and engage in a tendering process.

**Proposed Timescale:** 25/03/2016

## **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:**

The provider had failed to ensure that all staff had up to date knowledge and skills, appropriate to their role, to respond to behaviour that was challenging and to support residents to manage their behaviour.

### **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:**

Challenging behaviour training was last held in October 2013. A copy of attendance sheets will be sent on to the Authority.

Training plan:

Challenging behaviour training-refresher training – 22/09/2015

Challenging behaviour training 15 and 29 September 2015

MAPA training October/November 2015-dates to be confirmed.

**Proposed Timescale:** 27/11/2015

**Theme:** Safe Services

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

The provider failed to ensure that staff had received training in the management of behaviour that was challenging including de-escalation and intervention techniques.

### **Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Challenging behaviour training was last held in October 2013. A copy of attendance sheets will be sent on to the Authority.

Challenging behaviour training-1 day refresher training – 22/09/2015

Challenging behaviour training 15 and 29 September 2015  
MAPA training October/November 2015-dates to be confirmed.

**Proposed Timescale:** 27/11/2015

**Theme:** Safe Services

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

The provider had failed to ensure that where restrictive procedures including physical, chemical or environmental restraint were used, they were applied in accordance with national policy and evidence based practice.

For example, a risk assessment was not in place for residents who required lap belts and staff were not recording times of use and observation of these residents.

**Action Required:**

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

Risk assessments will be completed in line with the new Risk management policy as already outlined, consent is in place for people who require the use of lap belts and bedrails.

The organisation needs to put in place a checklist for documentation of safe use of these practices. We will need to include same in policy and require approval from the board of management

**Proposed Timescale:** 30/09/2015 for checklist of safe use of restrictive practices.16/10/2015 for full implementation of risk management policy.

**Theme:** Safe Services

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

The provider failed to put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

-not all residents had been supported to develop personal, intimate care plans.

**Action Required:**

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

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

'How you can support me' has a section on an individual's personal/intimate care needs. These were done in conjunction with the individuals. People who require minimal



supports outline same in their plan and in some cases people tell us the supports they require in regard to this. We have begun a review of this so that everyone's intimate care needs are documented in 'How you can support me'

**Proposed Timescale:** 17/08/2015

**Theme:** Safe Services

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

The provider had failed to ensure that all staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**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:**

Our Designated Person held Vulnerable Adult training in Sept 2012. Vulnerable adult training is being rolled out again on June 18 and July 02. Training will be complete by the 03/07/2015.

**Proposed Timescale:** 03/07/2015

**Theme:** Safe Services

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

The provider had failed to protect all residents from allegations of financial abuse:

- robust procedures were not in place to ensure that large amounts of residents' money were not stored in the centre.
- residents were required to contribute towards staff to accompany them on overnight stays and concerts etc.

**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:**

Some residents financial affairs are managed by their families and monies are brought by the residents family members on a regular basis. The people we support have varying measures in place concerning their personal finances. We have a Personal Money and Property Policy in place, this policy needs to be reviewed with regard to all the situations that currently present.

In regard to Family members bringing monies into the designated centre for their family member we are asking them to co-sign the monies in.

The organisation also has a policy for Personal Money and Property, which outlines the supports in place for residents in managing their own monies. We also have a Group Home finances Policy.

The Organisation will review all these relevant policies to ensure compliance with the Regulations.

All policies that are reviewed are done so by the policy review group and have to go the Board for final approval.

**Proposed Timescale:** 30/09/2015

### **Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

A resident with a swallowing difficulty did not have access to the SALT since 2014.

**Action Required:**

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

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

The person identified has been referred to the SALT for review.

The individual is currently waiting for an appointment with the FEDS team. (feeding, eating, drinking and swallow team).

In the interim the pharmacist has been made aware of the individuals swallow care plan and will advise on any new medications prescribed.

**Proposed Timescale:** SALT review – 31 July 2015 FEDS- 30 September 2015

### **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:**

Medication prescribing and administration in the system was not in line with best practice guidelines.

Not all pharmacists in the centre were facilitated to meet his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

Appropriate support was not provided for the resident in the type of documentation provided to the centre to prevent or minimise errors and to promote safe medication practice.

**Action Required:**

Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

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

The organisation has begun a consultation process with pharmacies in the area regarding a MARs sheet that would better facilitate the administration of medications and recording of same.

The current policy is under review, any changes will have to be approved by the Board.

**Proposed Timescale:** 30/10/2015

**Theme:** Health and Development

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

The provider had not 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.

For example:

- some medication administration sheets did not have identifying information recorded on them
- drugs were recorded as given with no time of administration indicated or recorded on the chart
- the dose of drugs was not indicated by the staff member administering the drugs
- not all boxed medications were individually labelled
- not all unused medications had been returned to the pharmacy
- drugs which were discontinued were not all signed and dated as such.

**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:**

The specific issues outlined above have been remedied in that particular house.

An in house audit of medication systems was put in place after the inspection to assist in identifying issues such as those outlined above.

The Medication Management Trainer left the organisation in April 2015. The Clinical Nurse Specialist now being tasked with reviewing our Medication systems will be reviewing the systems in place in the residential houses to ensure that appropriate systems are in place.

**Proposed Timescale:** 31/08/2015

**Theme:** Health and Development

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

A risk assessment and assessment of capacity had not been carried out to 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.

**Action Required:**

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

The organisation supports and encourages 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.

Our current Medication management policy makes provision for this but has not been carried out yet in all areas. This will be carried out in the proposed timeframe.

**Proposed Timescale:** 30/09/2015

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not contain the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

For example:

- there was no reference in the statement of purpose to access to training, employment and education for residents
- the statement of purpose did not specify a description of all room sizes and function in the centre
- the governance and management structure in the centre had not been updated in light of changes to senior management staff
- an updated statement of purpose had not been submitted to the Authority as required

**Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Our Statement of Purpose is currently being updated to include the required information.

**Proposed Timescale:** 14/07/2015

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

The provider had failed to put in place a clearly defined management structure in the designated centre that identified the lines of authority and accountability, specified roles, and detailed responsibilities for all areas of service provision.

**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 of the designated centre is in place, we are currently updating the registration to HIQA with a new PIC for the designated centre. The Statement of purpose is being reviewed to reflect this.

**Proposed Timescale:** 14/07/2015

**Theme:** Leadership, Governance and Management

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

The provider had failed to put management systems in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

**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 of the designated centre is in place, we are currently updating the registration to HIQA with a new PIC for the designated centre. The Statement of purpose is being reviewed to reflect this.

**Proposed Timescale:** 14/07/2015

**Theme:** Leadership, Governance and Management

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

The annual review of the quality and safety of care and support in the designated centre did not provide for consultation with residents and their representatives.

**Action Required:**

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

We are beginning a Quality of life survey in the designated centre which will involve consultation with residents and their representatives.

**Proposed Timescale:** 11/08/2015

**Theme:** Leadership, Governance and Management

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

The provider had failed 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. The provider had failed to 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.

**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:**

The yearly Health and Safety monitoring visit is taking place on June 29, the subsequent report and actions arising will be made available to Residents and their representatives.

**Proposed Timescale:** 03/07/2015

**Theme:** Leadership, Governance and Management

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

The provider had failed to put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering.

**Action Required:**

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

The organisation has a Supervision policy, which provides for a yearly appraisal and

quarterly supervisions. Social care leaders and Social care workers yearly appraisals are carried out with the Residential Manager. SCL/SCW carry out appraisals with the Support Staff they supervise. Quarterly supervisions are to be carried out in the same way.

The above have commenced in line with the policy and all appraisals will be done for the end of July.

**Proposed Timescale:** 31/07/2015

**Theme:** Leadership, Governance and Management

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

The provider had failed to make a copy of the report of the unannounced visit to the designated centre, available on request to residents and their representatives and to the chief inspector.

**Action Required:**

Under Regulation 23 (2) (b) you are required to: Maintain a copy of the report of the unannounced visit to the designated centre and make it available on request to residents and their representatives and the chief inspector.

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

The yearly Health and Safety monitoring visit is taking place on June 29, the subsequent report and actions arising will be made available to residents and their representatives.

**Proposed Timescale:** 31/07/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

In the sample of staff files seen by inspectors, the provider had failed to ensure that information and documents, as specified in Schedule 2, were obtained for all staff.

**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:**

The HR department have conducted a gap analysis of the personnel files and have contacted staff where required to attain the information required. A lot of information has been gathered. There is a checklist in place in each file to indicate the contents of the individual file.

An audit will now be put in place to monitor progress of this in line with Schedule 2 of the regulations. We will use staff rosters and our audit checklist to ensure all current files are in compliance with the requirements of Schedule 2.

For new staff joining the organisation, we endeavour to complete their new file in line

with schedule 2 requirements prior to their first payroll. The file will be audited against the schedule 2 audit checklist to ensure compliance before it is filed away.

**Proposed Timescale:** 10/08/2015

**Theme:** Responsive Workforce

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

The provider had failed to ensure that all staff had access to appropriate and mandatory training, including refresher training, as part of a continuous professional development programme.

For example:

- medication management to include specialist epilepsy training
- managing challenging behaviour
- abuse prevention training
- mandatory fire training

**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:**

Epilepsy and Buccal midazolam training- completed and attendance sheets sent to the Authority.

Challenging behaviour- September 15 and 29, refresher training September 22. MAPA October/November 2015-date to be confirmed.

Vulnerable adult training- June 18 2015 and July 02 2015

Mandatory Fire Training- completed and attendance sheets sent to the Authority.

**Proposed Timescale:** 27/11/2015

**Theme:** Responsive Workforce

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

The provider failed to ensure that all staff were appropriately supervised and all staff appraisals were yet to be done.

**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 organisation has a Supervision policy, which provided for a yearly appraisal and quarterly supervisions.

Social care leaders and Social care workers yearly appraisals were to be carried out with the Residential Manager.

SCL/SCW will carry out appraisals with the Support Staff they supervise.

Quarterly supervisions are to be carried out in the same way.



The above has commenced in line with the policy and all appraisals will be done for the end of July.

**Proposed Timescale:** 31/07/2015

### **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Not all policies in the centre were adopted and implemented such as the risk management policy, the policy on restrictive procedures and the medication management policy.

**Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The organisation has begun a consultation process with pharmacies in the area regarding a MARs sheet that would better facilitate the administration of medications and recording of same.

The current policy is under review, any changes will have to be approved by the Board.

The medication management trainer left the organisation in April 2015. The Clinical Nurse Specialist now being tasked with reviewing our medication systems will be reviewing the policy for the organisation. The timeframe is outlined below.

We are in the process of adopting a new risk management policy which is in line with regulatory requirements.

We rolled out training on June 03 2015 to frontline staff to facilitate the implementation of this policy.

We are working to a timeframe of four months to fully implement this policy in our residential houses.

By the end of the period each designated centre will have a risk register in place for the premises and the individuals being supported.

The organisation needs to put in place a checklist for the purpose of safe use of restrictive practices. We will need to include same in policy and require approval from the Board of Management.

**Proposed Timescale:** Medication management-16/10/2015; Risk management policy-16/10/2015; Restrictive practices – 30/09/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

The provider failed to maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

**Action Required:**

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

The HR department have conducted a gap analysis of the personnel files and have contacted staff where required to attain the information required. A lot of information has been gathered. There is a checklist in place in each file to indicate the contents of the individual file.

An audit will now be put in place to monitor progress of this in line with Schedule 2 of the regulations. We will use staff rosters and our audit checklist to ensure all current files are in compliance with the requirements of Schedule 2.

For new staff joining the organisation, we endeavour to complete their new file in line with schedule 2 requirements prior to their first payroll. The file will be audited against the schedule 2 audit checklist to ensure compliance before it is filed away.

**Proposed Timescale:** 10/08/2015**Theme:** Use of Information**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The provider failed to maintain and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

For example:

-records of medication errors

-records on the administration of medication, signed and dated, the dosage of each drug, administration of drugs in accordance with professional guidelines as per Schedule 3 (h)

-a restraints log which indicated the duration of restraint in use as per Schedule 3 (m)

**Action Required:**

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

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

Records of medication errors are reported on Xyea and are accessible by the PIC for the designated centre.

Drug administration records are kept in the houses.

The Medication Management Trainer left the organisation in April 2015. The Clinical Nurse Specialist now being tasked with reviewing our Medication systems will be reviewing our current medication practices will be reviewed to ensure they are effective.

The organisation needs to put in place a checklist for the purposes of safe use of restrictive practices such as lap belts and bed rails. We will need to include same in policy and require approval from the Board of Management.

**Proposed Timescale:** Review of current medication practices- 31/08/2015;  
Implementation of checklist and inclusion in policy – 30/09/2015

**Theme:** Use of Information

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

The provider had failed to maintain and make available for inspection by the chief inspector, all the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

For example:

-complete and comprehensive records of complaints were not available in each house

**Action Required:**

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

All complaints pertinent to a designated centre are kept and accessible to the designated centre on XYEA.

The PIC has oversight of the House Issues Book to ensure that informal/local issues are dealt with effectively and in a timely manner.

The PIC has access to the complaints reported on XYEA which apply to the designated centre.

**Proposed Timescale:** 16/06/2015

