

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002586
Centre county:	Dublin 16
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Paudie Galvin
Lead inspector:	Deirdre Byrne
Support inspector(s):	Shane Walsh
Type of inspection	Announced
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
28 July 2015 09:30	28 July 2015 19:30
29 July 2015 10:00	29 July 2015 18:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This registration monitoring inspection of Good Counsel and Westfield House was announced and took place over two days. The centre is part of the parent organisation the Health Service Executive. The purpose of the inspection was to assess compliance with 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.

Prior to the inspection on the 21 July 2015, inspectors visited the centre and an office off site to review policies, procedures, staff files and training records. During

the inspection, inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation. Questionnaires from relatives and residents submitted as part of the inspection were also read. These were discussed with the provider and are outlined in the report.

The designated centre comprises of six units- two units are currently in operation and four units are not yet occupied. There is a de-congregation plan for one of the occupied units. The Authority was advised in early 2015 that a transition plan was in place for residents and planned moves would commence in early summer of 2015. However, due to unforeseen delays the transition plan for residents has been delayed. Inspectors found there was insufficient consultation with residents to discuss the delays and their concerns.

Inspectors were not satisfied that the provider had ensured compliance with the Regulations, and areas of non-compliance were identified over nearly all 18 outcomes monitored. Furthermore, an area of significant non-compliance regarding the temperature of hot water from wash hand basins in residents' toilets was identified. The provider was required to take immediate action which was promptly carried out. The other areas of non compliance were in relation to outcomes on fire safety, risk management, governance, consultation with residents, social care needs, prevention of abuse and behaviours that challenge, medication management and the workforce.

The provider had failed to submit a complete application to register the designated centre prior to the inspection as required the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) (Amendment) Regulations 2015. An admission to the centre increased the number of residents from 22 to 23. However, the Authority had not been informed of the increase in numbers. The provider nominee was advised to submit a revised application form to reflect the increase in the number of residents in the designated centre.

There was some evidence of good practice in the centre. Residents were familiar with the staff, which in turn were knowledgeable of the residents health and social care needs. Inspectors found that residents were supported to develop and maintain personal relationships and that family were encouraged and welcomed to be involved in the lives of residents. The person in charge and staff responded effectively to the communication support needs of residents.

Inspectors found that the provider and the person in charge had only addressed three of the 13 actions from the previous inspection. There were one in progress and nine were incomplete. These non compliances are discussed in the body of the report and included in the action plan at the end of this 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:

Inspectors found the management of complaints in the centre required improvement. There were systems in place to consult with residents, however, improvements were also identified in this area.

The systems in place to manage complaints required improvement. A complaints policy and procedure were seen by inspectors. However, the procedures were not accessible to all residents. For example, there were no procedures displayed in one unit. While there were records of complaints maintained in a log book, the documentation and completion of these as per the Regulations required improvement. For example, the log book was accessible to all staff and residents and did not ensure individual complaints were managed confidentially. It was not clear if all complaints had been fully investigated or what the outcome was. There was no record of the satisfaction of those making complaints. This was discussed with the person in charge during the inspection who assured inspectors action would be taken.

There were improvements required to ensure residents privacy and dignity was maintained. Locks were not provided on the shower and bedroom doors in one unit to ensure residents privacy. A complaint read outlined residents concerns of staff entering the shower room without knocking. However, there was lack of action taken to satisfactorily address the issue.

There was evidence of consultation with residents with regular meetings held with them, with some improvements identified in relation to the unit that was in the process of decongregating. While minutes of meetings read confirmed residents were excited about

the planned moves which will entail them moving to their own home, there was lack of consultation around the delays in the planned move and how to dispel residents fears. For example, during the inspection some residents asked inspectors had they seen their new home and when were they moving in. There was a lack of information on what management were doing to inform or consult with the residents around the delays, supporting them to manage their concerns and providing realistic information to prevent disappointment. A day service that operated in the unit was also planned to close. Residents raised concerns about this to inspectors and it was also reported in relatives' questionnaires. However, there was no evidence of consultation or feedback provided to residents on what day service they would be attending in the future.

There was some information on an independent advocacy service. However, it was located on each resident's files and not displayed in an accessible place for residents to see. A social inclusion officer met with residents independently at a group called the "speak easy" and minutes of these meetings were read. However, the minutes were located along with the weekly resident meetings held by staff, which didn't ensure confidentiality of issues raised.

Residents could make choices about their daily lives such as when to go to bed, what food to eat and how to spend their free time. However, residents told inspectors that they had not been a holiday in a number of years and would like to go on one. This was discussed with the person in charge who outlined internal discussion regarding this.

A policy on the care of residents' property and finances was in place. However, an area of improvement regarding residents personal monies was identified. The residents did not have a bank account in their own name. This was an action at the previous inspection and had not been addressed. The provider informed inspectors it was in progress.

All residents required a level of support to manage their day to day monies. The provider and person in charge had put satisfactory arrangements in place to protect the property and the finances of residents. Records read confirmed there were two signatures maintained for each transaction.

Residents were supported and encouraged to take responsibility for personalising their own bedrooms. However, there were no lists of residents' possessions kept. See outcome 18.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Inspectors were satisfied that the person in charge ensured the communication support needs of residents were met. Pictorial images were used to support residents to make choices in their day, for example menu choices. Staff were aware of the communication needs of residents and these were clearly described in the communication “passports” maintained on file for each resident.</p> <p>The centre had access to radio, television, internet, and information on local events. The residents participated in local services and had links with the neighbourhood, through day services, active retirement, leisure and social activities.</p>
<p>Judgment: Compliant</p>

<p>Outcome 03: Family and personal relationships and links with the community <i>Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.</i></p>
<p>Theme: Individualised Supports and Care</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.</p> <p>Residents told inspectors that family members and friends could visit at any time and some residents said that they visited their family home regularly. Inspectors spoke with relatives who confirmed this. They were regularly consulted with about their loved ones care and were invited to attend meetings on care planning and specific health care decisions. Both residents and staff confirmed that visitors were always welcome, and there areas and rooms to meet visitors in private in the units of the centre visited.</p>
<p>Judgment: Compliant</p>

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

There were policies and procedures on the transition and discharge from the service of residents to the centre. However, a review of planned admissions to the centre by the provider was required.

During the inspection, inspectors were made aware that 23 residents were living in the centre, this was an increase of one from the original number of 22 however, the Authority had not been notified of the admission. The provider nominee was advised to resubmit the application form to reflect the correct number of residents in the centre. There was no transparent criteria for admitting new residents in the statement of purpose even though a decongregation plan was in place.

Inspectors reviewed the transitions and discharge policy, inspectors were informed prior to the inspection that the centre was to be de-congregated by Summer 2015. A transition plan had been developed for each resident. This is discussed in more detail in Outcome 1.

There was a contract of care in place that detailed the supports, care and welfare of the residents in the designated centre along with the services provided and the fees to be charged. It was signed by the residents or their representative.

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):

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

Findings:

Inspectors found each resident's wellbeing were maintained by a good standard of care and support and there were personal plans written with the participation of each resident. However, improvements were identified in the development of personal plans and the provision of holidays for residents.

Inspectors found the residents' welfare and wellbeing was maintained by a good standard of care and support by staff who were familiar with their health care needs. The residents had a mild to moderate disability which required staff support and assistance. An annual assessment of the residents social and emotional care needs was completed. Inspectors reviewed a sample of residents' personal plans. Each resident had a personal plan developed called a "person centred plan". However, the goals in place were not holistic and did not consistently provide for positive outcomes in their lives. For example, three of the plans were mainly focused on health care needs or risks identified and one resident's goal were duplicated each year.

There were regular reviews of each residents' goals. An annual meeting took place with the resident's which their family or representative were invited to attend. One resident discussed her plan with inspectors and told them about the annual meeting. While many of the plans were developed with photos of the residents along with pictorial images, the goals were not in an accessible format for the residents to understand.

The provider had ensured the residents were provided with interesting things to do during the day that was reflective of their assessed needs. During the day some of the residents attend a number of activities and day services on the grounds of the centre. Some residents also attended day services and workshops external to the service. There were trips during the day that included drives, coffee breaks, beauty treatments and library. There were a number of external persons who visited the centre to provide hand and foot massage and exercise classes.

A number of residents were now at retirement age, and there were retirement plans developed for the residents. There were plans in place around residents' transition into the community from one unit.

Some residents reported to inspectors during the inspection that they would like to go on holiday but were told it could not happen. This was also reported in questionnaires. The lack of holidays was reported at the previous inspection also. This was discussed with the person in charge who acknowledged there was a deficit in the provision of trips away. She confirmed there had been ongoing talks with the registered provider regarding the resources required and the availability of staff. The person in charge was hopeful the matter would be addressed in the coming months and holidays would be arranged.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

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

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

Findings:

Inspectors found the design and layout of one occupied unit within the designated centre did not meet the residents needs and the requirements of the Regulations. There is a decongregation plan in place for residents to transition into the community by the Summer of 2015. However, due to unforeseen issues delays the transition plan will take place later than expected. This is discussed under Outcome 1 in more detail. The centre consists of six units. Four of the units are unoccupied and two units are occupied. All units were visited by inspectors.

Unit 1:

This unit is in a suburban area in close proximity to the local community and the city centre. The unit is on the first floor of a large three story building. The building is set on its own grounds. There are currently 14 residents living in the unit. As reported above the design and layout of the unit did not fully meet the requirements of the Regulations, and did not meet the needs of the residents. The deficits with the building were as follows:

- the building where the unit is located is a large three storey building, with long corridors, hallways and open stairwells- it has not been fully assessed for potential risks and barriers to residents independence. Please see outcome 7 (health and safety)

- the entrance to the premises is by a common entry area, accessible by visitors and staff to external day services based within the building. This could also pose a risk to residents in terms of access to the unit. See outcome 7.

- the building is not maintained in good standard of repair. For example, plaster was crumbling from walls, holes were in walls from wiring, the floors torn in areas and rusting radiators. In some bedrooms the plaster was crumbling on walls and there were small holes in the walls

- the unit is not homely or decorated to a good standard. For example, halls, communal

areas and bathroom /toilet areas were clinical in design and layout

-parts of the building were not maintained to a good standard of cleanliness such as the laundry area, parts of the communal area and hallways

The bedrooms are located on the first floor, accessible by lift and staircase. They are all single occupancy. Inspectors visited a number of residents bedrooms. While they were small in size with limited space around the bed, there were no negative outcomes for residents as no resident currently required assistance or specialist equipment to mobilise. All bedrooms were provided with adequate storage and a wash hand basin. Some residents had added personal touches, with photos, paintings and personal possessions. There are staff offices, a catering kitchen, dining room, laundry, two day services and a large oratory on the ground floor.

Unit 2:

Inspectors found the second unit met the requirements of the Regulations. The unit is set in a more rural location. It has transport links to the local community and the city centre. It is set in a campus setting, and surrounded by nicely landscaped grounds that residents may access. It may accommodate up to nine residents. The resident bedrooms are single occupancy and large in size, with en-suite toilet and shower. Each bedroom was provided with large window or a balcony. Inspectors were invited into one resident's bedroom. It was nicely decorated and the resident confirmed she was very happy with it. There was a secure entrance to the premises, which was located on the first floor of a two storey building. A lift accessed all floors of the building. Two kitchen and dining areas and a large sitting room, all of which were nicely decorated and furnished, with soft seating, paintings and pictures throughout. There was adequate number of toilets, showers and bathrooms provided.

The remaining four units visited are unoccupied. They are located in an urban residential area close to the city centre. There is a bus stop outside the entrance. There is a shared gated entrance and communal garden. The units are yet to be furnished and fitted with kitchen equipment. The provider was advised to submit photographic evidence to the Authority once fully furnished.

Unit 3 and 4

These units are ground floor one bedroom apartments, with an occupancy for one person each. They are mirror images of each other. The entrance opens into a large entrance/hallway. The bedroom is off the entrance hall. It has adequate space and storage for clothing and personal possessions. There is a spacious open plan kitchen-dining-living area, with large windows providing natural light. A shower room with toilet and wash hand basin provided. Storage for equipment and personal possessions is provided. The unit is very tastefully finished, with tiled and carpeted flooring. A small paved garden shared with other units is provided.

Unit 5:

The unit is a first floor two bedroom apartment. It has occupancy of two residents. The

entrance opens into a wide stair well with bedrooms on the first floor level. The bedrooms have ample space and storage for clothing/personal possessions. A shower room with toilet and wash hand basin provided. There is a large open plan kitchen-dining-living room with large windows providing natural light. Storage for equipment is provided. The unit is very tastefully finished, with tiled and carpeted flooring. On the ground floor is a shared garden area. There is no lift provided. The person in charge is aware that any resident admitted to the unit will need to be professionally assessed as being independent in the use the staircase.

Unit 6:

The unit is a two storey floor five bedroom house, with occupancy for five residents. A large entrance area is provided, with store rooms and a ground floor toilet. There are three bedrooms on the ground floor and two bedrooms on the first floor. All bedrooms are provided with an en-suite shower, toilet and wash hand basin. There is adequate space and storage for clothing and personal possessions. There are two sitting areas. There is a large kitchen-dining with direct access to a paved shared garden area. There are large windows providing natural light. The unit is very tastefully finished, with tiled and carpeted flooring. There is no lift provided. The person in charge is aware that any resident admitted to first floor of the unit will need to be professionally assessed as being independent in the use the staircase.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Inspectors were not satisfied that adequate systems were in place to ensure the health and safety of residents, staff and visitors to the designated centre were promoted and protected. There were improvements required in relation to the response to deficits in fire safety and the management of risk.

Inspectors were concerned that fire safety deficits identified by the registered provider had not been followed up and addressed in a timely manner. Inspectors read fire safety reports from June 2014 that had been commissioned by the provider. A significant number of high risk issues were found that included deficits in fire doors with recommendations that they should be addressed within 3-6 months however,

appropriate action had yet to be taken in one unit to address the issues. Correspondence relating to the unit confirmed action was to be taken for six of the 66 high risk issues identified. The provider confirmed that works in the second unit were to commence on 3 August 2015.

Records read confirmed most staff completed training although five staff had not completed up-to-date training. There was a plan in place for the staff to attend training in September 2015 (see outcome 17). The staff who were spoken with were familiar with the procedures to follow if the fire alarm went off.

The fire exits in the centre were unobstructed and records read confirmed these were checked by staff. There were regular staff fire drills which residents took part in, and records were maintained for drills. There were arrangements in place to service of fire equipment and regular servicing took place along with the fire alarms and emergency lighting. At this inspection service records were available for review, this was an action from the previous inspection and completed. Fire evacuation procedures were displayed in each of the premises.

The identification and assessment of risk in the centre required improvement. There was a risk management policy in place. However, it was not implemented in practice, as areas of risk were identified in the centre. For example, the temperatures of hot water at wash hand basins used by residents in one unit measured over 55 degrees celsius. This was in excess of the minimum standard of 43 degrees and posed a significant risk of scalds to vulnerable residents. The matter was addressed when brought to the person in charge's attention. Although temperature checks were carried out and high temperature had been recorded no action had been taken to mitigate the risk.

Inspectors identified other areas of risk that included a very loose hand rail on a stairwell on the 2nd floor of one unit, and an unlocked room storing chemical cleaning agents. However, these issues had not been identified by management during recent safety checks carried out in the centre.

The staff completed risk assessment for residents, for example risk associated with falls, smoking, access to cleaning agents, and use of equipment for individuals. However, there was lack of monitoring of the risks identified as identified above and staff were not aware of the implication of the risks when brought to their attention.

The systems in place to manage adverse events were not robust and required improvement. A summary sheet of incidents was read by inspectors, that included a brief description of each incident and the action taken. A high number of incidents occurred in the centre, such as medication errors, falls, absconsions, choking incidents and behaviours that challenge. A sample of detailed incident forms were reviewed. The person in charge said the incident forms were reviewed and seen by the director of nursing. They were then submitted internally to the parent organisation of the Health Services Executive. However, there was no analysis or trending of the data for improvement and learning. Minutes of a management meeting held in June included information on the number of incidents in April. However, there was no evidence of what follow up action had been taken to prevent their recurrence.

A health and safety statement was seen by inspectors. There was an emergency plan in place, which included the alternative accommodation options in the event of an evacuation.

Personal evacuation procedures were in place for each resident and reviewed regularly. These included residents' likes and dislikes and prompts for staff if residents have difficulty in taking part in evacuations. Staff were familiar with the residents' evacuations plans.

A policy on the prevention and control of infection was read by inspectors. There were hand gels present throughout all units in the centre and hand-washing guidelines were displayed for staff.

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):

No actions were required from the previous inspection.

Findings:

There were systems in place to safeguard residents and protect them from the risk of abuse. However, improvement was needed in the development of behaviour support plans, and an area of restrictive practice in the centre.

There was a policy and procedure on the prevention, detection and response to abuse for adults. It included the definitions of different types of abuse including neglect and psychological abuse. It had been updated to be in line with the recent National Health Service Executive (HSE) policy on protection.

The person in charge was clear of her role in any safeguarding response and very clear around the process of managing an allegation of abuse and its investigation. At the time of inspection, there were no cases of allegations of abuse recorded. The director of nursing was the designated person who investigated allegation of abuse, with the person in charge deputising in her absence. Residents told inspectors that they felt safe in their home, and feel respected by the staff.

Staff members had received training in adult protection, with a small number of staff who had not (this is discussed under outcome 17). The staff spoken with on the day of the inspection were clear on what constitutes abuse and what action to take if they suspected or witnessed abuse taking place. However, staff who worked at night time were not clear on how they would respond to an incident. This was discussed with the person in charge who undertook to address the matter.

All residents were seen to be treated with respect by the staff. There was also a respectful relationship between the residents living together in the unit. Mostly residents enjoyed living together and friendly interactions were also observed by inspectors.

All residents were seen to have an assessment of their intimate support needs as part of their personal support plan. The plans encouraged residents to maintain and develop personal care skills, but also receive the support they need.

Where residents had behaviour that challenged this was recorded and there were strategies in place to manage any incident. Furthermore, staff were knowledgeable of the strategies and described the positive supports in place. However, in one example read the triggers to and the strategies in response to the resident's behaviours described by staff were not included. For example, they did not describe how the resident reacted and interacted when they were stressed or anxious. This could result in confusion and staff not knowing what to expect or how to respond. There was support available from a specialist team called the evaluation and intensive support team (Eist) who carried out reviews of residents when a referral was made. The team included a nurse who specialised in behaviours that challenge.

There was a policy on positive behaviour support read by inspectors. However, it would not provide sufficient guidance to staff. For example, procedure to pre-empt/manage behaviours, incident reporting and when to refer to the Eist committee. See outcome 18.

There were policies in place in the service about the use of restraint. Inspectors were informed that limited restrictive practices were in place, with a number of residents who required chemical restraint. This was managed in line with the policy, and there protocols in place around its use. However, it was noted that the kitchenette in one unit was locked, and residents were restricted from entering it. The reason was given because of one resident's behaviour. However, no risk assessment review or monitoring had been carried out. This was not in line with the National Policy "Towards of Restraint Free Environment".

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding any incidents and accidents. The person in charge was clear of what incidents needed to be notified and the timescales in which they must be notified to the Authority. To the knowledge of inspectors all incidents and accidents were reported clearly, and in a timely manner.

Judgment:

Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Inspectors found residents had opportunities for new experiences, social participation, education and employment.

Residents were encouraged to take part in a range of activities, both in the house, and in their day services. There was an annual "open day" in the centre, which was taking place on the second day of the inspection. Resident told inspectors about the event, which included games, sports, an award giving ceremony, music, food and fun. Families and residents from other designated centres were invited to attend.

Inspectors spoke with the some residents about these activities and all reported they enjoyed their options and routines, and did things that were of interest to them. For other residents reviews were seen to have taken place whether other opportunities should be explored such as for those thinking about retirement.

Residents told inspectors about their social lives, and shared experiences of recent events such as going on trips to the Wicklow mountains, to coffee shops, trips out shopping, or out in to the local parks. One resident said that she enjoyed going to bingo during the week or out for dinner during at the weekends.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Inspectors found residents' were supported to achieve and enjoy the best possible health, with improvements identified around mealtime experience in one unit of the centre. An action from the last inspection regarding completion of health care plans was addressed.

Inspectors reviewed a sample of resident files and found that residents had access to medical and allied healthcare professionals. These included, but were not limited to, a general practitioner (GP), dentist, occupational therapist, dietician, dentist, psychiatrist and physiotherapist. The files indicated that access to these services was timely, and residents were facilitated by staff to receive any recommended treatments.

A sample of residents' health care plans were reviewed. These formed part of their main file. Inspectors found the plans were comprehensive to guide practice and were reviewed very frequently, as much as every three months. The recommendations of allied health professionals were also incorporated into plans.

Evidence based assessment tools were used to complete regular reviews of the residents health care needs. Where residents were currently undergoing medical treatments/tests this was noted in the residents' files for follow up and staff were aware of any particular current needs.

There were procedures in place for end-of-life care. There was access to palliative care teams, and referrals were seen to be made by the GP when required. Resident preferences and wishes were recorded, and there was evidence of consultation with families on the future care of their loved one. One family member spoken with outlined the regular consultation with staff, and how they always ensured that they were kept up to date and included on any discussions around their loved one.

Inspectors found that where a resident refused treatment this was clearly documented, and strategies were in place to guide staff around this and to record all incidents of refusal.

There were good practices in place for residents to make healthy living choices around food. The main lunchtime meal for one unit was prepared off site in another location. The residents would come to the main dining room for their meal and pictorial images of meals were displayed each day. The residents could receive their breakfast and evening meal in a dining room close to their bedrooms. However, residents were not supported to make a cup of tea or prepare snacks independently during the day as the kitchenette was kept locked, see outcome 8 for more information.

Inspectors visited the kitchen in the unit and met the chef on duty, who described the range of meals provided to residents. The chef was knowledgeable of residents identified special dietary requirements, and up-to-date documented information on the residents needs were read.

There were good practices observed at the second unit. An area of improvement identified at the previous inspection was addressed and a chef was now present in the unit seven days a week to make dinners. The residents now received freshly prepared meals on every day.

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):

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that each resident was protected by the designated centre's policies and procedures for medication management. There were a number of improvements required and actions are under Outcomes 14 and 18.

The medication policy reviewed guided practice. Inspectors read a sample of completed prescription and administration records and saw that overall they were in line with best practice guidelines. However, one resident's prescription for medications would not guide practice. For example, the dose was not stated for all of regular medications and the maximum dosage of "as required" (PRN) medications were not consistently prescribed.

The practices carried out by staff on the ordering and management of out of date and unused medications were reviewed. However, the practices described by staff were

informal and undocumented. For example, there was no formal system of maintaining records of medications delivered to the centre and no local protocol in place to guide staff. This could pose a risk if medications were to go missing or be unaccounted for.

There were medication audits for the centre although the issues outlined above had not been identified.

The pharmacist was involved in medication safety and provided support and advice as required. Information pertaining to each resident's medication was available in the resident's files. Currently only staff nurses administered medications. The person in charge confirmed that all nurses completed on line training. In addition, a two day medication management course had commenced, and four nurses had completed the training to date. There were plans in place for all nursing staff to complete the training.

There were no medications that required strict controls in place, but staff outlined the procedure they would follow.

There were robust procedures for reporting medication errors. A number of medication error reports were read by inspectors and the errors were investigated by the person in charge or the director of nursing. It was evident appropriate action would be taken to prevent errors recurring.

There was a policy in place to guide safe practice in residents who choose to self medicate. No residents had chosen to self medicate in the centre.

Judgment:

Compliant

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:

Inspectors found that the Statement of Purpose did not fully meet the requirements of the regulations. For example, it did not fully describe all of the units in the designated centre, the layout of each unit, the admission process in place and the room sizes were not included. Feedback was provided to the management team on the deficits in this document.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Inspectors were satisfied that the person in charge was suitably qualified, experienced and full time in her role. She fully participated in the inspection process and demonstrated appropriate knowledge of the Regulations. The residents were familiar with the person in charge who was observed to spend time to talk and interact with them.

The centre was operated by the Health Service Executive and there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision of the service. The management team included the provider nominee (director of services), director of nursing, person in charge and clinical nurse manager grade two (CNM2). However, inspectors were not satisfied that the governance and management arrangements provided an adequate level of supervision of care and practice in order for the centre to be in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This was supported by the findings of this inspection, with examples as follows:

- the complaints process in place was not adequate,
- there was no evidence of consultation with residents and their relatives with regard to the delays in the decongregation of one unit in the centre,
- lack of a timely response and action to fire safety deficits identified in the centre,
- the management of risk was not effective,
- there was inadequate evidence of a systematic process for the ongoing review of quality and safety in the centre,
- staff were not formally supervised and not facilitated with adequate training to support them to provide evidence-based care,
- the lines of authority and accountability in one unit of the centre were not clear to all

staff, staff were not aware of the lines of authority in place, and staff meetings were not held in the unit.

The provider had failed submit a complete application to register the centre as per the requirements of the Regulations. During the inspection the provider nominee was advised to re-submit an application to reflect all the units and the number of residents in the centre.

The provider nominee and director of nursing had carried out unannounced visits to the centre in the last year, and the reports of these visits and their action plans were read.

There was an overall annual review of the safety and quality of the service as required by Regulations. This was an action from the previous inspection and completed. The audit had yet to be made into an accessible version for residents, and the provider nominee acknowledged at the feedback meeting that this would be addressed.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The provider nominee was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days.

The provider nominee had appropriate contingency plans in place to manage any such absence. There were satisfactory arrangements in place through the availability of a CNM2 to cover absences of the person in charge. The CNM2 demonstrated a clear understanding of her role and responsibilities under the Regulations if required to deputise for the person in charge.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

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

Findings:

Inspectors found that sufficient resources were provided to meet the needs of residents. There was sufficient staff to meet the needs of the residents. An action from the previous inspection was completed, and a chef was available in one unit each day to prepare meals.

Each resident was supported to spend their time in a way that suited them. The residents went out daily to access other services, with some choosing to stay home on certain days.

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:

Inspectors observed that there was sufficient staff with the experience to meet the assessed needs of the residents at the time of the inspection. However, improvements were required to ensure staff were suitably recruited, supervised, trained and had the right skills for the role they carried out.

Residents were seen to have a good relationship with staff and received any support they needed in a respectful, timely and safe manner. Where residents had specific communication styles, staff were aware of this and responded appropriately. The staff

knew the residents well.

A sample of staff files were reviewed in terms of the documents required by the Regulations. However, a number of gaps were identified, for example, there were no references available on two staff files, along with a job description. This had been an action at the previous inspection and had not been addressed.

Staff training records were reviewed. However, the records did not provide adequate evidence that all mandatory training provided was up-to-date, as discussed under Outcomes 7 and 8. While most staff had either a nursing qualification or a Further Education and Award Council Level 5 certification, they had not been provided with training specifically in the area of disability.

There was no formal system of staff supervision or appraisal. The person in charge informed inspectors that a new supervision policy was due to be implemented, and formal appraisals would be carried out with staff. This was an issue at the previous inspection, and the action was not yet addressed.

The staffing levels on duty at night time and the weekends in one unit was questioned in one relative's questionnaire. On the day of inspection there were enough staff to meet the resident's needs, and the roster showed there were consistent staffing levels. There were two staff based in the unit at night time, and three staff during the day. This was discussed the person in charge who acknowledged improvements could be made to ensure all residents social care needs were being met however, they were satisfied with staffing levels in the unit.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

Inspectors found that there were systems in place to maintain complete and accurate records and the required policies were in place.

Most of the written operational policies were in place to inform practice and provide guidance to staff. Inspector found that staff members were sufficiently knowledgeable regarding these operational policies. However, improvement regarding staff understanding of the policy on the prevention of abuse as described in Outcome 8 was identified.

As discussed in Outcome 8, the policy on positive behaviour supports was not comprehensive to direct staff. The policy on risk management was not implemented in practice as outlined in Outcome 7. The policy on the management of complaints was not reflected in practice as detailed under Outcome 1.

Inspectors found that the documentation of medical records required improvement, as outlined in Outcome 12. The maintenance of other records, relating to residents and staff was in a secure manner.

The directory of residents was up-to-date, and there was satisfactory evidence of insurance cover was in place. Inspector read the residents' guide and found that it provided detail in relation to all of the required areas. This document described the terms and conditions in respect of the accommodation provided and provided a summary of the complaints procedure.

Judgment:

Non Compliant - Moderate

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:

Deirdre Byrne
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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002586
Date of Inspection:	28 & 29 July 2015
Date of response:	28 September 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 Registered Provider is failing to comply with a regulatory requirement in the following respect:

The privacy of residents when using the communal shower and bathrooms required improvement.

There was no locks on the door of the communal shower room in one unit.

1. Action Required:

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

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Action:

- Locks have now been fitted to the door of the identified communal shower unit

Proposed Timescale: 28/09/2015

Theme: Individualised Supports and Care

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

There was no evidence of consultation with residents with regards delays around planned moves into the community.

2. Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

Action Plan:

- The Registered Provider has arranged for consultation meetings with residents through the residents weekly forum meetings to inform them about the delays in planned moves into the community. The Person in Charge has been identified as a resource person for all residents who may request further time and information on the planned moves. At this meeting the move to their new home and the continued provision of day services will be discussed i.e. location, activities etc.
- Residents will be briefed individually re any delays in relation to the moves via the key worker system. Resident's individual transition plans have been amended to reflect their individual consultation meetings.
- For residents that experience difficulties and anxieties around timing and their ability to process of delay, the registered provider has arranged for Multidisciplinary inputs. These inputs are reflected in the resident's communication and behaviour support plans.
- The Communication/Visual Board in the Designated Centre will continue to provide news and the regular updating for residents regarding the progress on their planned move.
- Visits will continue to be arranged for residents and their family to view and have meals in their new home where appropriate. These visits will continue until their transfer has taken place.
- The facilitator (Social Inclusion Officer) of the monthly Speak Easy group (Resident advocacy facilitated meeting) will explore with residents their understanding and satisfaction level with the amount of consultation from management that they are receiving around their planned move. Their feedback will be passed on to the Person in Charge and Registered Provider.

- The Registered Provider or nominee will attend the Speak Easy meeting on a Quarterly basis. These meetings will be minuted and available for inspection.
- The Centres Annual Report will reflect the consultation process and outcomes reached at these Speak Easy meetings.

Proposed Timescale: 24/11/2015

Theme: Individualised Supports and Care

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

Information on advocacy services available to residents was not clearly displayed to residents.

3. Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

Action Plan:

- The Registered Provider has arranged for information about the National Advocacy Service to be available in an accessible format.
- This information is displayed on the Designated Centres Communication Boards for the residents and family members information.
- Representatives from the National Advocacy Service have attended the Advocacy Speak Easy group since inspection and provided contact detail with information for residents re their office.
- Accessing Advocacy services is discussed with residents during the weekly forum meeting.

Proposed Timescale: 28/09/2015

Theme: Individualised Supports and Care

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

The residents own monies were not paid into a financial institution of their own name.

4. Action Required:

Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

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

Action Plan : The Registered Provider or any member of staff, will not pay money

belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

- The Registered Provider has identified three residents residing in the Designated Centre that has financial capacity to manage their finances and have been facilitated in opening a bank account.
- The Registered Provider shall ensure that any resident that is deemed not to have financial capacity will have their finances managed in line with HSE Regulations.
- The HSE Financial Regulations govern the financial activities in this Designated Centre. However the HSE is aware that this arrangement is not in compliance with the HIQA Financial standard and is in discussion with HIQA re same.
- The Registered Provider has highlighted this anomaly regarding HIQA regulation with the HSE.
- The HSE National Office has been in dialogue with HIQA re this anomaly. To date the Registered Provider awaits instruction from the Parent Organisation in relation to the regularisation of this anomaly.

Proposed Timescale: 01/01/2016

Theme: Individualised Supports and Care

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

Residents were not facilitated to go on holidays.

5. Action Required:

Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

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

- HSE Finance Department have outstanding issues in relation to previous holidays and instructed that no holidays are to take place until these outstanding issues have been resolved.
- The Registered Provider is engaging in an ongoing dialogue with HSE Finance Department in the resolution of this matter.
- The Registered Provider has organised for day trips and special events to occur over the summer in the ongoing absence of organised holidays for the residents.
- The Registered Provider has engaged with HSE Finance Department in developing a policy for residents holidays that will meet both the HSE's Finance Department and residents requirements.
- The Reregistered Provider has met with and is meeting with HSE Finance Department to resolve this matter. There are a number of outstanding issues that required resolution.
- The delays in the annual holidays are being discussed with residents at the residents forum and residents have been facilitated to choose locations for their day trips.

Proposed Timescale: 10/10/2015

Theme: Individualised Supports and Care

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

The complaints procedure was not prominently displayed in the centre.

6. Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

- The Registered Provider has ensured that the accessible Complaints Procedure is displayed on the Communication Board in the Designated Centre for the information of the residents and Visitors.
- The accessible/easy read Complaint Policy and complaints forms are discussed at the resident's weekly forum meetings.
- At these meeting residents are supported to understand what a complaint is and are made aware that their concerns will be addressed.
- The accessible Complaints Policy is discussed on a weekly basis at the resident's forum to ensure residents understand the process and of how to make a complaint.
- Resident are supported in making complaints by staff, family or advocate if requested.

Proposed Timescale: 28/09/2015

Theme: Individualised Supports and Care

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

It is was not clear if all complaints on record had been fully investigated.

7. Action Required:

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

Action Plan:

- The Registered Provider has developed a complaints form for the recording and investigation of complaints. This form clearly demonstrates the process of how complaints are managed within the Designated Centre.
- The form reflects the Complaint Policy's requirement. In the form each stage of the Complaint Procedure is captured. Stage 1: Local Resolution records the date and detail of complaint and any immediate resolution (if any). The complaint and outcome should be discussed with the PIC. Stage 2: Local investigation: A complaint that could not or should not be resolved at the first point of contact will be forwarded to the Complaint Officer (Director of Service). The Complaints Officer may consider whether practicable

to attempt a informal resolution of the complaint. When informal resolution is not appropriate or unsuccessful the Complaint Officer will initiate a formal investigation of the complaint. Stage 3: Internal Review. Following investigation if the complainant is not satisfied with the outcome/ response from the Complaints Officer they have the right to an internal review by the HSE Consumer Affairs department. Stage 4: Independent review where the complainant has gone through all the stages outlined and remains unsatisfied with the outcome. The complaint can forward to the office of the Ombudsman and or the Office of the Confidential Recipient.

- At the resident's weekly forum, consultation will take place re: the effectiveness and satisfaction level residents have around the complaint process.
- At the monthly management meeting, all complaints will be reviewed to ensure, due process has taken place and was satisfactory resolutions achieved.
- The service will review complaints for future training needs and service developments.
- Complaints are logged in the designated centre and forward centrally to HSE Consumer affairs.

Proposed Timescale: 28/09/2015

Theme: Individualised Supports and Care

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

It was not evident if residents were informed of the outcome of their complaint and whether or not they were satisfied.

8. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

Action Plan:

- The Registered Provider reviewed the Complaints Policy and has adopted a complaints form that reflects the complainant satisfaction level. Each stage of the Designated Centres Complaint Policy is adhered to. Stage 1: Local Resolution. Stage 2: Local investigation Stage 3: Internal Review. Stage 4: Independent review.
- The Clinical Nurse Manager 2 will feedback to the complainant on the investigation process and their level of satisfaction on the process which will be sought and documented.
- At the resident's weekly forum, consultation will take place re the effectiveness and satisfaction with the complaint process.
- At the monthly management meeting, all complaints will be reviewed to ensure, due process has taken place and was satisfactory resolutions achieved.
- The service will review complaints for future training needs and service developments.
- Complaints are logged in the designated centre and forward centrally to HSE Consumer affairs.

Proposed Timescale: 28/09/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

An admission made to one unit was not in accordance with a transition plan to decongregate one unit of the designated centre.

9. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

- The Registered Provider will ensure that there will be no further admissions to the designated centre.
- The Statement of Purpose for the Designated Centre has been amended to reflect this.

Proposed Timescale: 28/09/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

The personal plans in place were not holistic and mainly focused on one aspect of residents lives such as health care needs.

10. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

Action Plan:

- The Person in Charge organised training in Personal Centred Planning for seven nursing staff to be skilled in assessing social and emotional needs in a holistic manner and mentoring other staff in the completion of personal centred plans.
- Social Role Valorisation training has been provided to staff in day services to compliment the Person Centred Planning process in the Designated Centre.
- The Person in Charge will ensure that all care plans are reviewed three monthly to identify any gaps, where residents care plans goals were not linking to their social care needs and ensure the goals have positive outcomes identified for the resident's life.

- The Person in Charge will audit personal plans on a six monthly basis to ensure that care plans have positive outcomes for the resident lives.

Proposed Timescale: 01/11/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Parts of one unit of the centre (outlined in the report) were not in a good standard of repair internally and externally.

11. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

- The HSE recognises the unsuitability of the living arrangements of the older building and is providing alternative accommodation to residents. The alternative accommodation are modern community based premises. The HSE plans for the closure of the older building in the designated centre on the 31st of December 2015.
- The alternative accommodations identified are in community based locations. One of the alternative accommodations consists of a seven bedded house and apartments (referred to in the inspectors report). This complex consists of a five bed roomed house all with ensuite. One, two bedded apartment with bathroom and two single bedded apartments ensuite. The second alternative accommodation is a five bedded house in Terenure. This house has five bedrooms, three are ensuite and a bathroom. It is planned that residents will move to the alternative accommodation before the end of the year.
- Given that the building is due to close in December 2015, HSE Maintenance Department will only provide essential maintenance for the older building in the Designated Centre.
- THE HSE recognise, although the centre is due for closure (December 31st 2015), this centre remains the residents home until that date and therefore the HSE will continue to ensure that the centre provides as safe and homely environment, as possible for the residents. This will be completed by a daily walk about by delegated staff. Following the walk about a maintenance checklist for action is forwarded to maintenance Department by the Clinical Nurse Manager 2.
- The management team will review the environmental risk assessments at the monthly management meetings.

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

Parts of one unit outlined in the report were not maintained to a good standard of cleanliness.

The unit was not suitably decorated in areas.

12. Action Required:

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

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

Action plan:

- The Registered Provider has increased the cleaning contract hours to address areas that require ongoing cleaning. i.e. Laundry
- The Registered Provider has put in place a roster for cleaning staff to ensure cleaning is completed in the laundry area.
- The Registered Provider has put in place a manager oversees the work to ensure that the cleaning of the whole building is to that of a high standard.
- The PIC/Delegate will inspect the area on a daily basis for cleanliness
- The Registered Provider will ensure that the building is audited every six month by Infection Control Officer to ensure that it is cleaned to a high level.
- The Registered Provider will continue to work on the decorating of the Designated Centre to a high standard reflecting a homely environment in the areas identified by the inspector, such as pictures, residents art work, personalised bed linen etc.. The residents will be consulted on a weekly basis at the resident forum for their inputs.
- The PIC/Delegate will inspect the area on a daily basis to ensure the unit is suitability decorated.
- The Registered Provider will ensure that unit is audited every month for level of decoration.

Proposed Timescale: 28/09/2015

Theme: Effective Services

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

One unit as outlined in the report, does not fully meet the residents identified needs.

13. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

- The HSE has planned for the closure of the older building in the designated centre on the 31ST of December 2015.
- The HSE has identified alternative accommodation for all fourteen residents of the

older building. The alternative accommodations identified are community based locations. One of the alternative accommodations consists of a seven bedded house and apartments (referred to in the inspectors report). This complex consists of a five bedded house all with ensuite. One, two bedded apartment with bathroom and two single bedded apartments all ensuite. The second alternative accommodation is a five bedded house in Terenure. This house has five bedrooms; three are ensuite and a bathroom. It is planned that residents will move to these alternative accommodations before the end of the year.

- The HSE has identified alternative accommodation for the one remaining residents to another HIQA approved designated centre.
- The Registered Provider has ensured that all residents via the weekly resident's forum group, communication board and the key working system are informed about completion of building works and the proposed dates for occupation (before Christmas 2015).
- The Registered Provider on securing a definitive date of transfer to new living accommodation will write to each resident and their family outlining the date and transfer details.
- On transfer the Registered Provider will update the resident's contract of care to reflect their new living accommodation and continues care contract.

Proposed Timescale: 31/12/2015

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 was not implemented in practice in the centre for example:

- areas of risk were identified by inspectors that had not been addressed or mitigated by the provider.
- the measures in place to monitor and manage risk in the centre were not effective.

14. 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:

- The temperature of the water was reduced by HSE Maintenance Department to a safe temperature level on the day of inspection.
- The HSE Maintenance Department identified a permanent solution for the water temperature. The Registered Provider forwarded their recommendations to HSE for financing. Given that the building is due for closure by December 31st 2015 the HSE is unwilling to fund the works as the temperature reduction is working safely.
- The temperature of the water will be checked and recorded on a daily basis by staff on

duty in the centre.

- The Registered Provider has completed a risk assessment around the areas identified by the inspectors.
- All environmental risks will be discussed at the monthly management team meetings and at the bi-monthly Health and Safety meetings.
- In the event where any necessary additional controls identified cannot be managed at local level they will be escalated via the HSE's Health Risk Register and up to senior management level.

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

The arrangements in place for management of adverse events involving residents required improvement.

15. Action Required:

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

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

Action Plan

- The Registered Provider will ensure that all incidents are analysed monthly for action and trending in order that improvements and learning are facilitated. The incidents analysis will look at causes, outcomes, actions taken and patterns.
- Person in Charge will liaise with Director of Nursing and Registered Provider in the day to day reporting of serious incidents and appropriate action to take place to manage and reduce such incidents.
- The HSE has linked the Designated Centre to their central risk management computerised system (NEAMS). All incidents will be inputted on the NEAMS system for analysis and follow up action where appropriate by HSE central. This follow up action would consist of training, resource allocation and other risk reduction measures that are beyond the control of local management.
- The Registered Provider has sourced and commissioned an additional computerised audit system that will analyse and trend data for the Designated Centre. This is an audit based self assessment programme using the triangulation process of observation, documentation and interview. Which will allow for spot checks and focus on audit outcomes, evidence, follow up actions and dealing with those actions in order to highlight improvement.
- The Registered Provider following an adverse event will develop an action plan to ensure controls have been identified and initiated and are on target to being implemented.
- The Registered Provider has instigated a specific monthly meeting to review all incidents and examine follow up actions. This meeting will also identify trends; review actions ensuring existing controls are adequate.

- The Registered Provider will continue to escalate to the CHO office, any risks that cannot be managed locally.

Proposed Timescale: 01/12/2015

Theme: Effective Services

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

The overall management and response to risk in the centre required improvement.

16. 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:

Action Plan

- The Registered Provider has assigned a clerical personnel to input data into the Parent Organisation's risk management computerised system (NEAMS). This system records, risk rating, trends and actions of all incidents in a timely manner.
- The Parent Organisation's Risk management computerised system is linked to the Parent Organisation Risk management structure. This will ensure that the management of adverse events is monitored robustly.
- The Registered Provider has sourced and commissioned an additional computerised audit system that will analyse and trend data for the Designated Centre.
- The Designated Centres Health and Safety committee will continue to meet bi-monthly.

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

There was a lack of timely response and action taken to the recommendations made in fire safety report commissioned by the provider.

17. Action Required:

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

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

- The Registered Provider escalated the Fire Safety Report to the Parent Organisation for actioning. The Parent Organisation advised that the actions recommended from the Fire Safety Report for the oldest unit of the Designated Centre, which required capital investment will not be prioritised as this unit is due for closure. However the works for

the second unit of the Designated Centre have been approved for completion by December 2015.

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

Not all staff had completed up-to-date refresher fire safety training.

18. Action Required:

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

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

- The Registered Provider has identified staff who are due for training.
- The Registered Provider has organised training for the staff identified.

Proposed Timescale: 01/10/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The behaviour support plan for one resident did not fully reflect the positive support strategies carried out by staff.

19. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

- The Registered Provider has organised for the EIST team to update the identified residents behaviour support plan in order that the positive support strategies that are being carried out by staff are documented and available for any new staff to familiarise themselves with.

Proposed Timescale: 30/09/2015

Theme: Safe Services

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

Restrictive practices in place had not been assessed or monitored in line with the National policy.

20. 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:

- The Registered Provider has arranged for risk assessment to be completed on any risks leading to restrictive practices.
- The Registered Provider will ensure that any restrictive practices are logged in a Restrictive Practices Log Book and reviewed in line with National Policy "Towards Restraint Free Environment".

Proposed Timescale: 30/09/2015

Theme: Safe Services

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

There were gaps in the refresher training provided to staff on the prevention of abuse.

21. 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:

- The Registered Provider has identified staff that are due for training.
- The Registered Provider has organised training for the staff identified.

Proposed Timescale: 01/11/2015

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:

Residents were not supported to prepare their own snacks or meals.

22. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable

and practicable, to buy, prepare and cook their own meals if they so wish.

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

Action Plan

- The Person in Charge has spoken with the Catering Department and day/residential service staff in supporting residents who wish to prepare snacks/meals.
- The Person in Charge has consulted with the residents via the resident's forum who wish to prepare their meals or snacks.
- The Person in Charge will review the Personal Plan to include a skills building goal.

Proposed Timescale: 30/10/2015

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 reflect the designated centre and it did not include all of the information required by Regulations.

23. Action Required:

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

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

The Registered Provider has reviewed and amended the Statement of Purpose to contain the information as set out in Schedule as identified by the inspectors: the designated centre to include the full description all of the units in the designated centre, the layout of each unit, the admission process in place and the room sizes. The necessary information has been forwarded to the HIQA registration team by the Registered Provider.

Proposed Timescale: 28/09/2015

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 not submitted a full and complete application to register the designated centre.

24. Action Required:

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

Action Plan

- The Registered Provider has submitted a completed application identifying all the units in the designated centre for inspection, layout and room sizes of the building.
- The Registered Provider has updated the centre application to reflect the numbers of residents living in the designated centre.
- The Registered Provider has up dated the Statement of Purpose to reflect the number of residents residing within the designated centre.

Proposed Timescale: 28/09/2015

Theme: Leadership, Governance and Management

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

The lack of effective governance in the centre resulted in poor outcomes for residents, which are outlined in the inspection report.

25. 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 Registered Provider has reviewed the service and put in place a plan to address the following issues in line Regulation 23 (1) (b) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. The Action Plan is as follows:

Complaints Process:

- The Registered Provider reviewed the Complaints Policy and has adopted a complaints form that reflects the complainant satisfaction level. Each stage of the Designated Centres Complaint Policy is adhered to. Stage 1: Local Resolution. Stage 2: Local investigation Stage 3: Internal Review. Stage 4: Independent review.
- The Clinical Nurse Manager 2 will feedback to the complainant on the investigation process and document their level of satisfaction on the process.
- At the residents weekly forum consultation will take place re the effectiveness and satisfaction with the complaint process.
- At the monthly management meeting all complaints will be reviewed to ensure, due process and was satisfactory resolutions achieved.
- The service will review complaints for future training needs and service developments.

Complaint re delayed move to alternative accommodation

- The Registered Provider has arranged for consultation meetings with residents through the residents weekly forum meetings to inform them about the delays in planned moves into the community. The Person in Charge has been identified as a resource person for all residents who may request further time and information on the planned moves. At this meeting the mover to their new home and the continued provision of day services will be discussed i.e. location, activities etc.
- Residents to be briefed individually re the delays in relation to their move and outline the date of completion (via the key worker system). Residents transition plan has been amended to reflect the individual consultation meetings
- For residents who experience difficulties and anxieties around the timing and processing of delay regarding their move, the registered provider has arranged for Multidisciplinary inputs. These inputs are reflected in the resident's communication and behaviour support plans.
- The Communication/Visual Board in the Designated Centre will continue to provide news and the regular updating for residents regarding the progress on their planned move.
- Visits will be continued to be arranged for residents and family to view and have meals in their new home where appropriate. These visits will continue until the transfer takes place.
- The facilitator (Social Inclusion Officer) of the monthly Speak Easy group (Resident advocacy facilitated meeting) will explore with residents their understanding and satisfaction level with the amount of consultation from management that they are receiving around their planned move. Their feedback will be passed on to the Person in Charge and Registered Provider.
- The Registered Provider or nominee will attend the Speak Easy meeting on a Quarterly basis. These meetings will be minuted and available for inspection.
- The Centres Annual Report will reflect the consultation process and outcomes reached at these speak easy meetings.

Risk and Health and Safety

- The PIC/Delegate will inspect the area on a daily basis to identify immediate and maintenance issues.
- The Registered Provider has organised for updates of the risk register around the areas identified by the inspectors.
- The Designated Centre has computerised system of risk management linked to the HSE's risk management structure. This will ensure that the management of adverse events is monitored robustly.
- The Registered Provider has sourced and commissioned an additional computerised audit system that will analyse and trend data for the Designated Centre. This computer programme will analyse and trend data for the Designated centre. This is an audit based self assessment programme using the triangulation process of observation, documentation and interview. Which will allow for spot checks and focus on audit outcomes, evidence, follow up actions and dealing with those actions to show improvement
- The Designated Centres Health and Safety Committee will continue to meet bi-monthly.
- All environmental risk will be discussed at the monthly management team meetings

and at bi-monthly Health and Safety meetings.

- In the event where any necessary additional controls identified cannot be managed at local level they will be escalated via the HSE Risk Register and up to senior management level.

Staff Supervision

- The Registered Provider has organised for training and the rolling out of a supervision programme as per Designated Centre's Supervision Policy.
- The Designated Centres managers including PIC have undertaken training on staff supervision; this is in line with best practice of Professional Practice Development.
- Supervision will be implemented for all staff over the next 12 months.
- The supervision system will start with staff in November and will have all staff under professional supervision by October 2016.

Line of Authority

- The Registered Provider has clarified the lines of authority and accountability in the unit identified by the inspectors. The line manager is named (CNM1) in the roster for the identified unit.
- All staff in the unit are now aware of the lines of authority and accountability
- Regular staff meetings are held since the inspection in the unit identified by the inspectors.

Completed Application

- The Registered Provider has submitted a completed application to register the Designated Centre as per the requirements of the regulations, identifying all the units in the designated centre for inspection, layout and room sizes of the building.
- The Registered Provider has updated the centre application to reflect the numbers of residents living in the designated centre.
- Payment of application fee
- Confirmation of the name of the designated centre (Good Counsel Service)
- Completed PIC form
- PPIM reference form for CNM2
- Planning compliance confirmation for all service units

Annual Review

- The Registered Provider will make the annual review of the safety and quality action plan following all unannounced visit by the Registered Provider into an accessible version for residents.

Proposed Timescale: 01/12/2015

Theme: Leadership, Governance and Management

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

The monitoring of the quality and safety of care and support provided to residents requires improvement.

26. 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 Registered Provider will ensure that an accessible version of the action plan following the unannounced visits is made available to residents.
- The Registered Provider in order that the service provided is safe, appropriate to residents' needs, consistent and is effectively monitored has organised the following: the updating of all risk assessments, robust risk management systems, review of the complaints procedure, improvements in management's consultation with residents regarding their planned moves, the implementation of supervision for frontline staff with clear lines of authority and accountability.

Proposed Timescale: 01/12/2015**Theme:** Leadership, Governance and Management**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

A copy of the annual report was not yet available to residents.

27. Action Required:

Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

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

- The Registered Provider will make the annual review of the safety and quality of the service into an accessible version for residents.

Proposed Timescale: 01/11/2015**Outcome 17: Workforce****Theme:** Responsive Workforce**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

There were gaps in the information required to be maintained by Regulations for each staff in the centre.

28. 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 Registered Provider has updated staff records in line Regulation 15 (5) and as specified in Schedule 2. The gaps identified by the inspectors have been addressed references are available for the two staff identified, along with a job description.
- Mandatory staff training was offered to all staff and records are now up to date.
- Training in the area of disability has been provided to staff as identified by the inspectors.
- The service managers including PIC have undertaken training on staff supervision/appraisal. This training will be implemented for all staff over the next 6 months.

Proposed Timescale: 01/04/2016

Theme: Responsive Workforce

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

There were gaps in the training required be provided to staff for example, prevention of abuse and fire safety training.

Most of the staff met and spoken with had not completed training in the area of disabilities.

29. Action Required:

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

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

- The Registered Provider is sourcing an external training agency to provide disability awareness training for staff.
- The Registered Provider has identified an on-line training programme on disability awareness for staff via the HSE training on line e hub intra net systems. Access to this training programme system will be made available to all staff. All staff will be required to submit their certificate of completion of this course.
- The Registered Provider has provided fire training and training in Safe Guarding Vulnerable Adult for identified staff in the inspectors report.

Proposed Timescale: 30/03/2016

Theme: Responsive Workforce

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

There was no formal system of supervision in place.

30. 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:

Action Plan :

- The Registered Provider has provided supervision training in line with the Designated Centres Supervision policy.
- The Designated Centres managers including PIC have undertaken training on staff supervision; this is in line with best practice of Professional Practice Development.
- Supervision will be implemented for all staff over the next 12 months.
- The supervision system will start with staff in November and will have all staff under professional supervision by October 2016.

Proposed Timescale: 01/05/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

Some of the policies in place were not fully implemented in practice. For example, the risk management policy, complaints policy.

The positive behaviour supports policy did not guide practice.

31. 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:

Action Plan :

- The Registered Provider has put in place a system for recording and investigating complaints. Which clearly demonstrates the process of how complaints are managed within the designated Centre.
- The Registered Provider will ensure the prompt investigation of complaints and the recording of the outcome(s) of such investigations.
- The Registered Provider has reviewed the Designated Centre's Complaints Policy to include a template which records whether the complaint was concluded to the satisfaction of the complainant and that the complainant/representative is aware of their right to appeal if they are dissatisfied with the outcome of their complaint.
- The Registered Provider will ensure that the accessible Complaints Procedure is displayed on the Communication Board in the Designated Centre for the information of

residents and visitors.

- The Registered Provider will ensure the Behaviour Support Policy is reviewed and will provide guidance around behaviour that staff may find challenging.

Proposed Timescale: 31/10/2015

Theme: Use of Information

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

Full and complete records of residents needs were not maintained as outlined in the report.

32. Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

Action Plan :

The Registered provider will ensure the Designated Centre will retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre: As identified in responses to :

- Outcome 1 Policy on the Management of Complaints
- Outcome 7, The Policy on Risk Management
- Outcome 8 the Policy on Positive Behaviour Supports,
- Outcome 12 Documentation of Medical Records.

Proposed Timescale: 01/12/2015