Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004646
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Angela O'Neill
Lead inspector:	Breeda Desmond
Support inspector(s):	Maria Scally; Noelene Dowling; Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 March 2015 07:30	10 March 2015 17:30
11 March 2015 08:30	11 March 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 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

On 6th November 2015, HIQA took the unprecedented step of applying to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities. The centres were St Raphael's Residential Centre, Oakvale and Youghal Community Hostels, all located on the grounds of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

This report relates to Youghal Community Hostels and is one of the nine inspections of these centres during 2015 which identified serious concerns in relation to safety of residents and poor quality of life for residents. As a result of poor governance and oversight of the centres, management had failed to identify these issues for themselves, failed to address them effectively and failed to ensure a safe and good quality service for residents.

This inspection of a Health Service Executive (HSE) centre for adults with disabilities was a triggered inspection following notification to the Authority of allegations of abuse. The inspection was unannounced and took place over two days. As part of

the inspection process inspectors met with residents, the person in charge (PIC), and other staff members. Inspectors interviewed staff, observed practices and reviewed documentation such as care plans, medical records, policies and procedures and staff files. Overall inspectors identified significant issues regarding governance, care and welfare and lack of compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) with Disabilities) Regulations 2013.

The layout of both premises were not fit for their intended purpose, cognisant of the aging population residing there. All bedrooms in Community hostel 2 were located upstairs and four of the five bedrooms in Community hostel 1 were upstairs; neither had stair lift or lift to access the first floor. The action plan submitted by the provider in relation to the premises and specifically the response to the action under Regulation 17 (1) (a) did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish the response to this action and is considering further regulatory action in relation to this issue.

Adequate fire safety precautions were not evidenced to ensure safety of residents. Appropriate risk assessments of residents were not evidenced to ensure safe and suitable care and welfare. During the inspection the provider was issued with an immediate action plan to address the risk associated with residents mobilising outside the designated centres.

Inspectors were not satisfied that there were adequate governance arrangements in place as evidenced by inadequate staffing with an over-reliance on overtime, significant deficiencies in staff training including adult protection and positive behavioural management, the absence of a systematic review of the quality and safety of care in the centre, and the absence of an effective complaints process; in addition the person in charge stated that she did not have the capacity to fulfill here role.

Irregularities regarding one resident's financial arrangements were identified and inspectors were not assured that all safeguarding arrangements were in place to safeguard the resident from financial and other abuse.

Other improvements required included:

- fire safety precautions with special attention for arrangements on night duty
- the emergency plan did not address the safe placement of residents in the event of a prolonged evacuation
- there was an inadequate process for managing risk
- the statement of purpose did not comprehensively detail information requested in Schedule 1 of the Regulations
- residents did not have a contract of care
- medication management consultation and administration documentation required attention
- there was inadequate evidence to demonstrate that any actions were taken following consultation with residents/relatives
- policies and procedures were not comprehensive

- person-centred plans required improvement
- staff personnel records were incomplete.

The action plan at the end of the report includes the immediate action plan issued to the provider and identifies additional improvements required 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 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

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):
This was the centre's first inspection by the Authority.

Findings:
Overall, inspectors were not satisfied that there was an effective complaints procedure in place to facilitate and support residents and/or their relatives to make a complaint. There was inadequate evidence to indicate that their complaints policy "your service, your say" was implemented in the centre. There was a local complaints policy, however it did not outline in sufficient detail the procedure for managing complaints; while the complaints officer was identified, an independent person other than the nominated person to deal with complaints was not identified, as required in the Regulations. The complaints log was reviewed in both hostels. The outcome of the complaints process or whether the complainant was satisfied with the outcome was not always recorded. There was no evidence of a process to oversee the complaints procedure in order to ensure compliance.

There was evidence of consultation with residents and their relatives in relation to the organisation of the centre with minutes of meetings reviewed, however, it was difficult to determine how effective these meetings were. For example, residents had not been consulted with regarding their dining arrangements Monday to Friday; residents dined in the main dining room on campus during the week and in their hostels Saturday and most Sundays they went to a restaurant. It was not evident from minutes reviewed if the residents decided on the menu choice or restaurant choice at weekends. A small number of residents had access to an independent advocate, however, it was difficult to determine the degree of access all residents had to advocacy services.

There were significant shortcomings in the design and layout of both premises that directly impacted the ability of staff to support the privacy and dignity of residents, for example, there were no privacy curtains between residents' beds in twin bedrooms.

Some residents' age profile was significantly younger than the average age profile of the other residents. A resident told the inspector that the placement did not meet their needs and was inappropriate.

The programme of activities included art therapy, music therapy, massage and horticulture. Most activities were facilitated on the main campus. There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests and capacities. One resident stated that they did not have 'activation services' appropriate to their needs or there was no one their 'own age' or with 'similar interests'.

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):
This was the centre's first inspection by the Authority.

Findings:
Documentation for recording the assessed needs of resident called 'My Assessment' was available in each resident's care plan. This included sections for recording residents' choice, education/learning, circulation and breathing, nutrition, mobility, communication, oral hygiene, men's/women's health and personal cleansing and dressing, however, these were only partially completed for many residents.

While staff reported to the inspectors that care planning documentation was in transition; some of the new records had commenced in September/October 2014 however, inspectors noted that they had not been completed to date. Staff members had received very little training in developing care plans and evidence of this was observed on inspection. While some care plans demonstrated good insight and consultation with residents, others did not. For example, afternoon tea and jogging were recorded as the interests for one quite elderly resident and the plan did not acknowledge the interest and pleasure that the resident had in looking after the cat. Information from medical notes did not inform another residents' 'Personal Health File', for example, inspectors read a file for a resident with a diagnosis of osteo-arthritis and

osteoporosis, yet their 'Personal Health File' indicated that their bone health was fine.

Many of the documents were neither signed or dated by the staff completing the assessments, so it was impossible to determine when their review dates were due. While most staff were observed to be kind and sensitive to residents needs, some of the commentary notes were not reflective of person-centred care, for example, the terms 'moody' and 'whinging' were used to describe residents with enduring mental health diagnoses.

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):
This was the centre's first inspection by the Authority.

Findings:
Community hostel 1 was located within the HSE campus and community hostel 2 was located approximately one kilometre away from the main campus. Both were very old buildings and it was difficult to determine how the design and layout could meet the individual needs of residents, cognisant of their ageing profile.

Both hostels were two-storey buildings. In community hostel 1, residents' accommodation comprised one single bedroom and four twin bedrooms, all with wash hand basin facilities; one twin bedroom was located down stairs and the remainder were upstairs with only stairs access to the first floor. Residents had personalised their bed area with photographs, mementos and furnishings of their choice. There was a large sunroom that was pleasantly decorated and had comfortable seating; there were separate dining facilities alongside the main entrance of the hostel. There was another large room with comfortable seating which also accommodated the nurse's station. The kitchen was located off the dining room, however, there was a ramp access down to the kitchen which had not been risk assessed for residents. There was a small open unsightly storage area located in the hallway which held a commode, wheelchair, several bags containing paper towels and bath towels. There was a shower-wet area with assisted toilet and hand wash facilities down stairs. Upstairs there was a bathroom with toilet, wash hand basin and shower area however, the joining between the wall and floor in the shower was quite unclean. Residents did not have the option to lock bathroom doors which potentially compromised their privacy and dignity. While some

residents' beds had pressure-relieving mattresses, others did not, they had domestic-type beds; clinical risk assessments regarding skin integrity and pressure were not completed on residents with increased dependency, consequently, the suitability of their mattresses could not be determined. There were no privacy curtains between residents' beds in twin bedrooms to enable privacy and dignity of residents. Some light shades were missing from residents' bedrooms.

The exit from the kitchen led to an enclosed backyard; the shed here housed the laundry facilities and one resident did their own laundry. However, the backyard contained a lot of rubble and rubbish, including an obsolete generator and broken tiles and was a potential risk of trips and falls to residents.

The road surface of the walkway from community hostel 1 to the dining room was quite uneven and unsuitable. One resident required a rollator to mobilise and two residents had decreased mobility and identified to inspectors that 'it was like the rocky road to Dublin' however, the use of this road not been risk assessed for residents.

Community hostel 2 was located within a walled property. Ten people resided here and their accommodation comprised five twin bedrooms with wash hand basins however, all were located upstairs with just stairs access and inspectors observed that several of the residents' had reduced mobility. Residents had personalised their bed area with photographs and furnishings of their choice. Sanitary facilities located upstairs comprised a toilet with wash hand basin; one shower and toilet was out-of-order for some time; there was another bathroom with a shower, assisted toilet and wash hand basin. Communal space comprised a large sitting room with comfortable seating, television and music centre; a dining room with tea and coffee making facilities. While the dining room floor was washed after breakfast, the chairs remained upturned on the dining tables throughout the day so residents were unable to sit in the dining room if they so wished, indicating that this arrangement was task orientated and not person centred. Residents had access to the kitchen, scullery and utility room. The smoking area was a porch located to the rear of the building, however, the steps leading from this area to the back garden were narrow and steep and egress for some residents would be difficult cognisant of their reduced mobility. Staff reported that this had been risk assessed and placement of hand-rails along the steps were awaited. While there were floor plans displayed in each hostel identifying where emergency fire safety equipment were located, it was not adequate as there was no point of reference (for example the front door) to assist residents and visitors was not identified.

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):
This was the centre's first inspection by the Authority.

Findings:
While there was a safety statement and health and safety and risk management policy in place however, hazard identification, assessment of risks with measures and actions to be taken, was not comprehensive. An emergency plan was also available but the evacuation location for residents to stay should the need arise, was not documented here.

The provider was issued with an immediate action plan on inspection as there was inadequate systems in place for the assessment, management and on-going review of residents' capacity to mobilise unsupervised outside the campus. This was of serious concern because there had been a previous road incident involving a resident. In addition appropriate risk assessments to ensure road safety and the degree of assistance and/or supervision was not demonstrated in the support plans reviewed.

Fire safety training records were reviewed which demonstrated that staff had completed training in April and June 2014. While some staff demonstrated knowledge of fire safety precautions, not all staff were aware of safety precautions and procedures. This was especially relevant to safety precautions on night duty in Community hostel 1 (nine residents) where there was just one staff rostered on duty at night time. While there was a brief outline of individual resident's assessment regarding fire safety precautions, an evidence-based risk assessment for personal emergency egress plan was not evidenced for each resident to ensure their safe and appropriate evacuation, should the need arise. The fire safety officer undertook an inspection of the Community hostel 2 premises and queried the official number of exit doors, however, there was no evidence of this information in the daily fire check list.

Lack of appropriate risk assessments with associated strategies to mitigate risk have been detailed throughout the report in addition to those described here:

· there were no window restrictors in the upstairs windows in Community hostel 1 to mitigate risk; this was not included in their hazard identification risk assessment.

· residents had unrestricted access to cleaning chemicals and protective equipment such as disposable gloves and aprons and these had not been risk assessed to ensure safety of residents.

While incidents and accidents were recorded, this data was not collated or analysed to identify trends to enable quality improvement measures to mitigate risk or potential risk.

There were hand wash sinks available for staff and advisory signage for best practice hand hygiene was displayed. There were a number of hand hygiene foam dispensers available; the inspector observed that many opportunities for hand hygiene to be completed in accordance with best practice guidelines were taken.

The smoking area was located in the porch area, however, this had not been risk

assessed to ensure safety of residents; fire safety equipment was not available here. The smoking policy advised that a risk assessment be completed when necessary but a risk management plan was not evidenced to support this.

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):
This was the centre's first inspection by the Authority.

Findings:
There was a policy on, and procedures in place, for the prevention, detection and response to abuse. While inspectors observed staff members interacting with residents in a respectful manner, some staff members spoken with by inspectors did not demonstrate adequate knowledge of what constituted abuse and what to do in the event of suspicions or allegations of abuse. In addition, some staff did not express confidence in reporting anything untoward. Following review of staff training records, inspectors identified that a significant number of staff had not received up-to-date training on the prevention, detection and response to abuse. Inspectors also noted that monitoring of protective systems to ensure safety of residents was not evidenced.

Based on a review of records and notification to the Authority, there were two allegations or suspicions of abuse in the designated centre. However, there was a delay in submission of the relevant notifications to the Authority as well as a delay in informing the next-of-kin of the residents'. These were discussed at length with the person in charge. Investigations were in progress at the time of inspection and reports from these investigations were awaited.

HIQA had been informed of an allegation that arrangements to manage resident's finances were inadequate and inspectors were not assured that all suitable precautions were in place to safeguard the resident from financial and other abuse. While this issue was brought to the attention of senior management some weeks prior to the inspection, the Authority had not received a notification relating to this matter and during the inspection this was highlighted to the person in charge.

There was a multi-disciplinary review of residents requiring behavioural support plans which included the psychiatrist, psychologist and care staff. One resident's positive behavioural support plan (PBSP) was reviewed by inspectors which demonstrated an in-depth knowledge of the resident's communication needs with clear guidelines for appropriate responses and pre-emptive stressors to avoid. Follow-up records showed a reduction in behaviours that challenge for this resident following implementation of the PBS plan. Nonetheless, only a small number of staff had received up-to-date training on identifying and alleviating the underlying causes of behaviours that challenge.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Some residents attended their individual general practioner off site in the local town. The medical officer attended the centre on a daily basis and residents had access to out-of-hour GP cover; there was evidence of regular reviews, referrals and specialist interventions when necessary. However, current or comprehensive medical notes of residents attending off-site GP services were not evidenced. This would be significant should a resident require out-of-hours GP services, the visiting GP would not have access to up-to-date medical history of the resident to inform safe and appropriate care.

Residents had ready access to some multidisciplinary services but limited or no access to others. For example, an occupational therapist was available on the HSE campus four days each week, a psychiatrist was available two days each week, a psychologist was available for one session each week and there was good access to dental services. However, there was limited access to services such as dietetics, physiotherapy and speech and language therapy; some residents had specialist dietary requirements and swallowing needs and reduced mobility, which would potentially benefit from allied health professional intervention.

In addition, clinical risk assessments to support and inform suitable and safe care were not in place in the sample of personal care plans reviewed, for example, falls risk or pressure area assessment (even though some residents had reduced mobility and were observed to be more dependant).

As previously mentioned in Outcome 5 Social Care Needs, documentation relating to

residents was in transition. However, while some of the personal support plans had valuable person-centred information to inform safe and appropriate care, many other were either blank or had very little information to capture relevant information. The inspector read of residents with specific health related care needs, however some records had not been updated since 2010. Others did not provide guidance to staff in the residents' care plans.

Meals were prepared in the main kitchen on campus and the main dining room was located alongside the kitchen. However, residents queued up to get their meal which was delivered through a hatch; there was just one staff member serving which resulted in long delays for residents; one resident was observed to wait 15 minutes to be served. Both residents and staff to whom inspectors spoke with were not aware that residents could dine in their houses if they so wished. Residents had menu choice at mealtimes and gave positive feedback regarding menus and quality of meals served.

Judgment:
Non Compliant - Moderate

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):
This was the centre's first inspection by the Authority.

Findings:
There was a current centre-specific medication management policy in place. A nurses' signature sheet as described in An Bord Altranais agus Cnáimhseachais na hÉireann medication guidelines, was evidenced. Residents' medication was stored securely in a locked trolley within the nurses' station.

Medication prescription and administration charts were reviewed and contained a code for non-administration of medicines. However, a record of non-administration of medicines was not always recorded for residents absent from the centre, for example, when residents went home at weekends. Other drug administration recording charts revealed blanks in the administration record however, these were not recorded as medication errors or reported to line management. Allergy status of residents was not recorded as part of their prescription/administration charts in line with best-practice professional guidelines. An erasing fluid was used in some administration charts viewed.

Photographic identification was in place as part of residents' prescriptions in line with best practice. There were separate prescriptions sheets for medical preparations and psychiatric medicines. However, there was no evidence that consultation between the

medical officer and psychiatrist occurred to mitigate risk of medication errors. Residents' prescriptions were reviewed regularly by the medical officer, signed and dated and items were discontinued appropriately. Maximum dosages for PRN (as required) medications were documented as well as the rationale for administration of PRN medicines.

Judgment:
Non Compliant - Moderate

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):
This was the centre's first inspection by the Authority.

Findings:
A written Statement of Purpose was in place. While it outlines some of the items listed in Schedule 1 of the Regulations, the following items required further attention:

1) the number and gender of residents which will be accommodated in the centre
2) the facilities which are to be provided by the registered provider to met the care and support needs of residents
3) a description of the rooms in the designated centre including their size
4) the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing complements as required in regulation 14 and 15
5) the organisation structure
6) supervision of use of specific therapeutic techniques
7) specific arrangements for respecting the privacy and dignity of residents
8) arrangements for residents to engage in social activities, hobbies and leisure interests
9) arrangements for residents to access education, training and employment
10) arrangements made for consultation with and participation of, residents in the operation of the designated centre was not included
11) arrangements made for residents to attend religious services of their choice
12) the arrangements made for dealing with complaints.

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):
This was the centre's first inspection by the Authority.

Findings:
The management structure in the centre was not clearly set out. While there was a person in charge, she was also responsible for other designated centres for residents with significant level of complexities, consequently, little time and input could be afforded to this centre.

The provider nominee and the person in charge confirmed that there was no annual review of the quality and safety of care as required by the regulations. An unannounced visit to the designated centre at least every six months to ensure the safety and quality of care and support provided in the centre, as described in the Regulations, was not undertaken. There was minimal evidence of an audit process to evaluate the quality of life and the quality of the service provided to residents. The sample of audits reviewed focused on documentation rather than on assessment of practice. Where audits had identified shortcomings, there was no process in place to address them. Inspectors were not satisfied that there were adequate systems in place for a review of the quality and safety of care in the designated centre.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors reviewed duty rosters for both community hostels however, the roster was not accurate and did not reflect some of the staff on duty during the inspection. The allocation for staff in community hostel 2 was one nurse and one carer on day duty and two staff on night duty; community hostel 1 staff allocation comprised one nurse and one carer on day duty and one carer on night duty. In community hostel 2, all allocated permanent nursing staff had been on long-term sick leave for some time. According to the duty rosters seen it was only in the weeks preceding the inspection that a permanent nurse was appointed to community hostel 2, however, there was no equivalent senior staff member to work opposite him. From speaking with staff and reviewing staffing records, inspectors formed the view that the arrangements to cover the duty roster, sick leave or emergencies were totally inadequate and there was an over-reliance on staff working prolonged periods of overtime. Inspectors noted that neither staff or residents knew who was coming on duty and relief staff may not always be familiar with residents. This was a significant issue cognisant of the complex communication and care needs of residents in the hostels. Staff reported to inspectors that residents became anxious when staff could not inform them who would be on duty. Inspectors noted that there were at least four days in the previous six weeks when only one staff member was available in one of the units. While fulltime nursing staff were required for each hostel during the day, on a number of days there was just a carer available.

A sample of staff files were reviewed which demonstrated that many of the items listed in Schedule 2 of the Regulations were not in place for staff, including:

1) photographic identification
2) details and documentary evidence of any relevant qualifications or accredited training of the person
3) two written references including a reference from a person's most recent employer (if any).

Comprehensive records were maintained of staff training however these records demonstrated that staff had significant deficiencies in their continuous professional development to enable them to deliver up-to-date evidenced-based care.

Judgment:
Non Compliant - Major

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

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Findings were discussed under Outcome 12 Medication management.

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:

Breeda Desmond
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004646
Date of Inspection:	10 March 2015
Date of response:	15 June 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no privacy curtains between residents' beds in twin bedrooms to enable privacy and dignity of residents.

1. Action Required:
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

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

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:
Curtain screening has been installed in the twin rooms in both community hostels. (30/4/15)

Proposed Timescale: 30/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests and capacities.

2. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
The Day service has recently completed a questionnaire with the Service Users to gain an awareness of their interests and activities, and is currently sourcing new activities based on their interests , capacities and developmental needs

Proposed Timescale: 31/05/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An effective complaints procedure to facilitate and support residents and/or their relatives to make a complaint was not evidenced. There was inadequate evidence to indicate that their complaints policy "your service, your say" was implemented in the centre.

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

Please state the actions you have taken or are planning to take:
The current complaints policy is being updated and will take cognisance of the concerns raised. An accessible version of the procedure will be made available for residents.
It is proposed that the individual PIC in each area will become a designated complaints

office and the complaints will be reviewed by the CNM3 each month.

A system will be developed to identify lessons learned from complaints so that the service and experiences for the services users can be improved. Complaints logged and how they were dealt with and the outcomes/satisfaction will be reviewed monthly and discussed at staff meetings to ensure compliance.

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An independent person other than the nominated person to deal with complaints was not identified in the complaints procedure.

4. 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:
The current complaints policy is being updated and will take cognisance of the concerns raised.
It is proposed that the individual PIC in each area will become a designated complaints officer and the complaints will be reviewed by the CNM3 each month. Should an independent review of any complaint be required as per "Your Service Your Say" this can be facilitated through the Director of Nursing or via the HSE Consumer Affairs department.

Proposed Timescale: 30/06/2015

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:
Clinical risk assessments to support and inform suitable and safe care were not in place in the sample of personal care plans reviewed, for example, falls risk or pressure area assessment (even though some residents had reduced mobility and were observed to be more dependant).

5. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
As part of the introduction of a new suite of documentation regarding care planning, appropriate risk assessments in line with identified residents care plans will be developed.
The current implementation of the new care plans to be completed which will include individual risk assessments and care plans to support the risks identified. All reviewed documentation will be dated and have guidelines on documenting details of when updated.
PIC and the staff team to receive training on Risk Assessments and Incident Reporting.
Auditing of the care plans to evaluate their implementation and to support team effectiveness and areas requiring support and learning.

Proposed Timescale: 30/09/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Many of the residents' care documents were neither signed or dated by the staff completing the assessments, so it was impossible to determine when their review dates were due.

6. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
The current implementation of new care plans will be completed. This will include the individual risk assessments and care plans to support the risks identified. All reviewed documentation will be dated and have guidelines on documenting details of when updated.
Auditing of the care plans to evaluate their implementation and to support team effectiveness and areas requiring support and learning.
The HSE Record Management policy will be highlighted to staff at unit meetings.

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Information from medical notes did not inform residents' 'Personal Health File',

7. 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:
A review of 'My Personal Health File' will be undertaken to ensure all diagnoses are updated in the service users' care plans

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not completed for all residents, with incorrect information in some plans and others were not including important information in relation to residents.

8. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
All staff have received training in practical care planning and documentation, A CNM3 has been allocated to support staff in developing and maintaining documentation that is specific and resident focused.

A review of the existing documentation will take place and any areas of concern will be addressed.

In line with the current review and implementation of Care Plans, planned review meetings will be held by the Key worker and PIC to include consultation with the Service User/Relative and invite the relevant multidisciplinary input where available.

Proposed Timescale: 31/08/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The layout of both premises were not fit for their intended purpose, cognisant of the aging population residing there.

9. 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 response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Matters to be provided for in premises of designated centres as listed in Schedule 6 were not in place.

10. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
The rubble and rubbish has been removed from the grounds of Hostel 1
The generator is in need of repair, parts are awaited, and in the event of not being sourced the generator will be replaced.
Suitable locks will be sourced for the bathroom doors based on the service users risk assessments.
The practice of chairs left upturned on the table has been discontinued.
Curtains are being sourced and will be installed in all shared twin bedrooms to support the dignity and privacy for each individual.
Suitable storage will be put in place which will also support easy access of the wheelchair.
A comprehensive Assessment to be completed for all Service Users which will include a detailed Occupational Therapist assessment to support adaptations required due to their increased dependency and reduced mobility cognisant to an aged related population. Suitable adaptation such as handrails ,grab rails equipment and facilities will be provided both internally and externally.
A request will be made for a comprehensive Health and Safety/ HSE Estates report on any structural adaptation required to put in place safety measures for the service users while awaiting alternative more suitable community facilities.

Proposed Timescale: 31/08/2015

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:
While there was a safety statement and health and safety and risk management policy in place hazard identification, assessment of risks with measures and actions to be taken, was not comprehensive.

11. 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 current safety statement and health and safety and risk management in place will be subject to a comprehensive review in association with input from the National quality improvement team.
Training has been arranged with the risk manager to address deficits in risk management and incident reporting.

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While incidents and accidents were recorded, this data was not collated or analysed to identify trends to enable quality improvement measures to mitigate risk or potential risk.

12. 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:
Training has been arranged with the risk manager to address deficits in risk management and incident reporting. This should result in an immediate improvement in systems.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An emergency plan was available but the evacuation location for residents to stay

should the need arise, was not documented here.

13. 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:
The service will review each resident emergency plan which will identify an area in the event of an emergency evacuation that will be needs assessed.

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no window restrictors in the upstairs windows in Community hostel 1 to mitigate risk; this was not included in their hazard identification risk assessment.

14. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
A risk assessment will be carried out by the CNM2 in this area. Appropriate controls to address the identified risk will be put in place. This will include the provision of appropriate window restrictors if necessary.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents had unrestricted access to cleaning chemicals and protective equipment such as disposable gloves and aprons and these had not been risk assessed to ensure safety of residents.

15. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
Appropriate risk assessments regarding the risks identified will be completed.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The road surface of the walkway from Community hostel 1 to the dining room was quite uneven; this had not been risk assessed for residents.

16. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
HSE Estates department have been contacted to assess the walkway with a view to resurfacing the road.

Risk assessments will be updated in the interim to reflect this risk

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there were floor plans displayed in each hostel identifying where emergency fire safety equipment were located, a point of reference (for example the front door) to assist residents and visitors was not identified.

17. Action Required:
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

Please state the actions you have taken or are planning to take:
Floor plans will be updated to a more accessible format
Contact will be made with the fire officer to discuss this requirement.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While some staff demonstrated knowledge of fire safety precautions, not all staff were aware of safety precautions and procedures.

18. 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:
All staff in these areas has up to date fire training.
Additional training and support will be given as required.
Fire evacuation and general fire safety measures will be reiterated to all staff at unit level meetings.
6 monthly fire drills will be held.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The smoking area was located in the porch area, however, this had not been risk assessed to ensure safety of residents; fire safety equipment was not available here.

19. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
Suitable fire safety equipment will be sourced and appropriate risk assessments will be completed.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there was a brief outline of individual resident's assessment regarding fire safety precautions, an evidence-based risk assessment for personal emergency egress plan was not evidenced for each resident to ensure their safe and appropriate evacuation, should the need arise.

20. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
The assessments regarding resident's fire safety will be updated to provide a more

comprehensive assessment which will take cognisance of any physical and communication difficulties that may hinder a successful evacuation

Proposed Timescale: 31/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Only a small number of staff had received up-to-date training on identifying and alleviating the underlying causes of behaviours that challenge.

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

Please state the actions you have taken or are planning to take:
Training in the area of challenging behaviour has been sourced and will be rolled out across the service in the next few months. Arrangements will be made to ensure that a number of staff from all areas of the service will be accommodated on this training asap. All staff will have completed training by 31/10/15.

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A significant number of staff had not received up-to-date training on the prevention, detection and response to abuse.

22. 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:
This training is currently on going within the centre and all staff will attend a 1 day programme in the upcoming months.
Informal staff briefings in both HSE Policies Trust in Care and Safe Guarding and protection have taken place and will continue

Proposed Timescale: 30/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff did not demonstrate adequate knowledge of what constituted abuse and what to do in the event of suspicions or allegations of abuse.

23. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
A programme in the area of safeguarding and protection, education of staff is ongoing. It has been reiterated to all staff of their duty to report any concerns re residents they may have.
As above – briefing for all staff is an ongoing process
1 day training - ongoing all staff will have attended training by 30/06/2015
Trust in Care - CNM's in each area attended a module on TIC on 07/04/2015

Proposed Timescale: 30/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Monitoring of protective systems to ensure safety of residents was not evidenced.

24. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
Staff training is ongoing in recognising all forms of abuse, reporting of same and supporting the residents. This will be completed by 30/6/15.
In line with the proposed closure plan residents will be consulted and assessed with regards to their needs to reside in more appropriate living environment. The consultation and assessment phase will be completed by 31/10/15.

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Irregularities regarding arrangements for the management of residents' finances were identified and inspectors were not assured that all safety precautions were in place to safeguard the resident from financial and other abuse.

25. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
In accordance with NFR22 all residents' income is held and accounted on a centre basis. Weekly expenditure is requisition by the CNM and accounted for at unit level.
These accounts are subject to yearly audit by outside auditors in addition to the local policy/procedures which have been distributed to all staff.

1 issue in relation to 1 resident's finances has been reported and is currently the subject of a formal investigation. The required notification for the resident has been submitted.

Proposed Timescale: 31/08/2015

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:
Current or comprehensive medical notes of residents attending off-site GP services were not evidenced. This would be significant should a resident require out-of-hours GP services, the visiting GP would not have access to up-to-date medical history of the resident to inform safe and appropriate care.

26. Action Required:
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:
Any medical concern is documented in the Nursing notes.
There have been discussions with the offsite GP and a comprehensive medical report will be issued for the residents to have in their medical notes in updating the careplans..
A system is being developed for the medical sheet to be avail at the G.P appointments for the G.P to enter the medical note to keep the records updated.

Proposed Timescale: 31/05/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was limited access to services such as dietetics, physiotherapy and speech and language therapy, cognisant of the aging profile of residents residing in the hostels.

27. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services

provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
All residents that were identified as requiring a speech & language assessment have accessed same. The speech and language therapist will review any other residents as appropriate or as their needs change.
An OT has recently commenced work on a part time basis. Residents will be prioritised and assessed as appropriate in consultation with the OT.
A dietician has been sourced and will commence work in the service shortly.

Proposed Timescale: 31/10/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents queued up to get their meal which was delivered through the hatch; there was just one staff member serving which resulted in long delays for residents; one resident was observed to wait 15 minutes to be served.

Residents spoken with and staff were not aware that residents could dine in their houses if they so wished.

28. Action Required:
Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

Please state the actions you have taken or are planning to take:
The provision of meals in the dining hall will be reviewed in consultation with the residents as to their preferred choice
This will form part of the decongregation of the centre to increase staffing in order to facilitate residents dining wishes.
Staffing levels will be looked at with regards to the dining hall

Proposed Timescale: 31/08/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A record of non-administration of medicines was not always recorded for residents absent from the centre, for example, when residents went home at weekends.

Other drug administration recording charts revealed blanks in the administration record;

these were not recorded as medication errors or reported to line management.

29. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Medication management practices will be reviewed.

Proposed Timescale: 31/05/2015

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 detail all the requirements listed in Schedule 1 of the Regulations.

30. 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 Statement of Purpose will be updated to support the service users in line with the proposed plans for community houses. Facilities and services provided for the service users in the transition and in identifying individual needs in the planning stage will be included.
The Statement of Purpose will be made available in an easy read format to the Service users and their representatives.

Proposed Timescale: 31/08/2015

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:
Inspectors were not satisfied that there was a clearly defined management structure that identified lines of authority and accountability for the designated centre.

31. 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:
A substantial change in staffing is planned for community hostel no.1. The current staff will be redeployed to other designated centres in the area. Social care workers will be assigned to the service. The SCWs will report to the CNM2 with designated responsibility for the service. The CNM2 will work closely with the PIC at CNM3 level and will report to the Director of Nursing.

In community hostel no. 2 there is a CNM1/ACNM1 on each shift who will report to the CNM2 with designated responsibility for the service.

The current statement of purpose will be updated to reflect this structure.
An updated organisational chart will be included in the statement of purpose.

Proposed Timescale: 31/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care as required by the regulations.

32. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
A system of regular audit is currently being explored in consultation with other service providers and the HSE Quality Improvement Team.
Liaison with the Quality Manager is ongoing regarding the potential to provide training for nurse management in audit systems.
The training being sourced through the Quality Manager) and Risk Manager will facilitate the development of an appropriate review system. It is envisaged that this could be completed by 30/9/15.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

the following respect:
An unannounced visit to the designated centre at least every six months to ensure the safety and quality of care and support provided in the centre, as described in the Regulations, was not undertaken.

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

Please state the actions you have taken or are planning to take:
However, an initial unannounced visit will be carried out by 24/4/15 focusing on

- staff awareness of safeguarding policy and procedures
- restraint procedures
- Progress on implementation of measures addressed in this action plan.

The Provider nominee did an unannounced visit on the 22nd April 2015 and completed a report on the safety and quality of care and the support provided in the centre.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there was a person in charge, she was also responsible for other designated centres with significant level of complexities, consequently, little time and input could be afforded to this centre.

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

Please state the actions you have taken or are planning to take:
A person in charge for this service is currently being agreed. The PIC will work closely with the designated CNM2 who will have line management responsibility for the staff in this service.

An external consultant has been identified to work in the service from August ’15 to support the performance management of the workforce and develop the competencies of staff to deliver quality services.

Proposed Timescale: 30/6/15 PIC and 1/10/15 consultant supports

Proposed Timescale: 01/10/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While fulltime nursing staff were required for each hostel during the day, on a number of days there was just a carer available.

Inspectors noted that there were at least four days in the previous six weeks when only one staff member was available in one of the units and similar findings in the second unit.

35. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
HSE has been attempting to recruit staff to this centre for some time, with limited success. (via HSE National Recruitment Agency and other Agency) Given the age profile of staff and the number of anticipated retirements recruitment will be addressed on an ongoing basis.
The following recruitment plan for this and three other designated centres in the area has been approved by HSE management.
1) recruitment of 12 Registered Nurses in ID through
- national and local competitions
- engagement of a recruitment agency on 'finder fee basis'
Target date for completion: 31.07.15
2) increasing Care Assistant Complement
- recruit 10 additional support staff (housekeeping role)
- re-assign 10 staff with FETAC qualifications from housekeeping to Care Assistant
Target date for completion: 30.6.15
3) Social Care Workers
- recruit 12 additional Social Care Workers and assign to replace nurses in community houses
- reassign nurses from community houses to St Raphael's Centre
Interviews will be held on 16th/17th June
Target date for completion: 30/6/15

The proposed staffing for Hostel 1 is 2 SCW working 8am-8pm Mon-Sun with I SCW working 8pm-8am (night duty) Mon- Sun with 1 additional SCW working 3pm -11pm Mon- Sun

Hostel 2 will initially remain with the current staffing of 1 Nurse & 1 Care assistant on day duty. On completion of the recruitment process an additional staff will be rostered on day duty.
The staffing is Hostel 2 has been strengthened by the addition of a S/N on night duty. In addition the number of residents in this hostel is expected to reduce to six in the coming weeks.

The initial focus of the recruitment plan is to reduce reliance on overtime. As the complement of staff available increases and reliance on overtime reduces, the service will be able to ensure on an ongoing basis that staffing levels and skill mix are maintained at appropriate levels.

Proposed Timescale: 31/07/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Frequently, neither staff or residents would know who was coming on duty and relief staff may not be familiar with residents. This was a significant issue cognisant of the complex communication and care needs of residents in the hostels. Staff reported to inspectors that residents became anxious when staff could not inform them who would be on duty.

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

Please state the actions you have taken or are planning to take:
Rosters are issued each Friday for the following week these are displayed in each office area.
Shortages are covered prior to rosters being issued in as far as reasonably practical.
The roster plans will be reviewed that on recruitment of new staff they will be allocated so that the rosters will be planned in advance and reflect the actual staff on duty.

Proposed Timescale: 30/06/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Many of the items listed in Schedule 2 of the Regulations were not in place for staff, including:

1) photographic identification
2) details and documentary evidence of any relevant qualifications or accredited training

of the person
3) two written references including a reference from a person's most recent employer (if any).

37. 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:
All staff files will be updated by 30/6/15.

Proposed Timescale: 30/06/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Comprehensive records were maintained of staff training which demonstrated that staff had significant deficiencies in their continuous professional development to enable them to deliver up-to-date evidenced-based care.

38. 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:
Due to ongoing staffing shortages this has had a negative impact in ensuring staff have access to appropriate training.
A recruitment process is ongoing at this time which will alleviate this shortage which will allow a comprehensive staff development programme to be rolled out in the centre.

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Allergy status of residents was not recorded as part of their prescription/administration charts.

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

Please state the actions you have taken or are planning to take:
Discussion will take place with both prescribing doctors in centre to ensure this practice will not occur again.

Proposed Timescale: 13/04/2015