

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
<b>Centre ID:</b>	OSV-0003731
<b>Centre county:</b>	Dublin 15
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Daughters of Charity Disability Support Services Ltd
<b>Provider Nominee:</b>	Lorraine Macken
<b>Lead inspector:</b>	Ciara McShane
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	14
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 08 June 2016 08:30 To: 08 June 2016 19:30

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

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 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

**Background to the inspection**

This was an unannounced inspection that was undertaken by the Health Information and Quality Authority (HIQA) to monitor ongoing compliance with the regulations. It was completed over one day. Actions from the centre's last inspection were also followed up with.

**How we gathered our evidence**

The inspector met with a number of the staff team including care staff, household staff and the nursing team. The inspector also met with the person in charge and the clinical nurse manager on duty. As part of the inspection the inspector spoke with staff, reviewed documents such as the centre's policies, the safety statement, personal plans and the statement of purpose. The inspector also completed a walk around of the premises. The inspector carried out observations throughout the day and communicated with a number of residents.

**Description of the service**

The provider had produced a document called the statement of purpose, as required by the regulations, which described the service provided. The statement of purpose stated the service catered for individuals who had physical disabilities, epilepsy, behaviours that challenge and other medical conditions such as diabetes.

The centre was a congregated setting situated on a large campus where there were six other designated centres. The centre comprised of dormitory style sleeping arrangements and two single rooms. Bathrooms and toilet facilities were communal. The centre was equipped with a sufficient number of bathrooms and showers to meet the needs of the residents. The centre also had a large lounge room which was nicely decorated and an additional smaller room where residents could relax or meet with family and friends. A dining room and kitchen was also available to residents. Due to the dormitory style nature and physical layout of the centre, the provider had agreed to cease admissions to the centre following the registration inspection in June 2014. The provider and HIQA were in agreement that this centre was not suitable to meet the ongoing needs of residents.

#### Summary of regulatory compliance

Eight outcomes were inspected against, two outcomes were found to be of major non-compliance with three moderate non-compliances. The inspector found that residents' healthcare needs were being met as reflected in their records. Areas for improvement were identified in terms of governance and management in addition to the staffing levels and opportunities for residents to engage with their community and participate in meaningful activities. Staff training was not up-to-date in areas of safeguarding, fire and manual handling. Other areas for improvement included the completion of risk assessments where risks had been identified and the provider's obligation to report notifiable events to HIQA.

These findings along with others are further detailed in the body of the report and the action plan at the end.

**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 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

The inspector found that there had been some improvement regarding the identification and fulfilling of residents' social care needs and aspirations since the previous inspection. However, further improvements were required.

Each resident had a personal plan that outlined, at a high level, their preferences for activities. These preferences formed, for the most part, part of their goal setting as opposed to a comprehensive assessment of their social care needs. The inspector observed and read that residents were involved, at times, in activation on campus and on occasion participated in activities off campus in the community. From a review of residents' activation logs that were maintained in their personal plan the inspector found that the level of activation residents participated in had improved since the previous inspection however, levels were still low. For example, for one resident over the period of a month, May 2016, they engaged in nine days of activation with a total of seven hours and 30 minutes participation. In terms of activities participated in outside of the centre, over a period of five months, it was recorded they had six outings. For another resident, the inspector found their activation levels over a period of a month, May 2016, totalled four and half hours over four days. Staff spoken with confirmed that since the last inspection activation levels had increased however, they were cognisant it had remained low and stated it was dependant on staffing levels. Reliance on staffing availability was also outlined as a factor in the goal setting for one resident's plan that was reviewed.

The inspector reviewed residents' goals and found that goals had been identified however, further information was required in terms of describing and evaluating the goal. For example, a goal for one resident was to attend social outings four to six times a year. It failed to detail what type of social outings they preferred to go on. Also the evaluations of goals were statements regarding the activity they participated in as opposed to an evaluation of the goal achieved. For example, the resident 'went to a shopping centre and had lunch'. The inspector found that goals were not at all times assisting residents with their development or maintenance of skills. The inspector found that regular and basic expectations such as visiting the hairdressers had been identified as a goal.

As part of the centre's last action plan the provider committed to completing activity sampling that would then form the basis of a yearly comprehensive assessment for each resident. The inspector reviewed the documentation for residents regarding activity sampling which was maintained for each resident and outlined the activities they participated in. However, it did not in all circumstances inform whether the resident enjoyed the activity, if it was beneficial to them and or if it was an activity the resident may wish to pursue. In addition, the inspector also found that it did not form the basis of an annual assessment.

Overall the inspector was not assured that residents had meaningful days that were fulfilling in terms of meeting their capabilities, aspirations and wishes. As observed by the inspector, and as further outlined in Outcome 17, the care provided to residents was predominantly task orientated with an absence of a focus on the social aspect of their care.

**Judgment:**  
Non Compliant - Major

**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):**

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

**Findings:**

Due to the dormitory style nature and physical layout of the centre, the provider had agreed to cease admissions to the centre following the registration inspection in June 2014. The dormitory style accommodation continued to have an impact on residents' privacy and dignity. The provider and HIQA were in agreement that this centre was not

suitable to meet the ongoing needs of residents.

The action from the previous inspection had been completed. An additional area had been created for the storage of wheelchairs and the bathroom was now accessible to residents. Staff at the centre told the inspector that a number of residents now used the bath. There was also a tracked hoist available in the bathroom to provide access to all residents.

The centre is deemed as a congregated setting and included dormitory style accommodation where 13 residents lived. Eleven of the residents lived on the dorm with two other residents whom also lived on the dorm however, they had their own single room at either end of the dorm. Another resident had their own accommodation area which was attached to the designated centre.

There was a separate dining area for residents to have their breakfast and dinner. There was a large lounge room which was nicely decorated and welcoming where residents were observed relaxing throughout the day. Residents also had access to an outside area. There was a swing chair near the front door of the centre which some residents enjoyed relaxing on.

There were adequate laundry facilities with a separate area where laundered clothes were pressed and sorted by a household member of staff. One of the residents often assisted with this activity.

Some minor areas for improvement were identified. One of the hand rails in the bathroom was broken and the rail, at the time of inspection, could therefore not be used. The broken rail was placed above a cabinet which also posed as a risk. Areas within the centre required cleaning as highlighted during the inspection. In addition, the paintwork on the ceiling of one of the resident's bedrooms was chipping away and required repainting. The resident also showed this to the inspector.

**Judgment:**  
Substantially Compliant

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

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

**Theme:**  
Effective Services

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

**Findings:**  
Overall it was found the health and safety of residents, visitors and staff was promoted and protected. There were arrangements in place, for the most part, to manage risk and

controls were in place to manage the risk of fire. Some improvements regarding risk management were highlighted during the inspection.

There was a health and safety statement in place that had recently been reviewed on the 22 September 2015. A policy on major emergency planning had been developed. It was complete with a list of numbers that staff may refer to should there be an emergency in addition to alternative accommodation possibilities being outlined. A risk management policy was in place which outlined the specifics as required by the regulations. A risk register was also in place that outlined potential risks. Individual risks pertaining to residents were outlined in their care plan.

The inspector was told of one resident who had a high risk of falls and whom had recently been reviewed at a multidisciplinary team meeting. The staff also stated hip protectors were prescribed for the resident and there was a plan to purchase sensor alarms. However, there was no risk assessment in place to reflect their risk of falls. There was a manual handling plan in place for this resident, however; it was not reflective of the recent falls or concerns regarding their gait and deterioration.

Controls were in place to manage the risk of fire. Individual risk assessments had been completed for each resident in terms of evacuation, although they had not been reviewed in over a year. There were clear evacuation maps throughout the centre in addition to a centre specific evacuation plan. Staff were familiar with the evacuation plan and a resident spoken with was able to tell the inspector what they would do in the instance of a fire. The centre completed regular fire drills and checks on equipment such as emergency lighting.

**Judgment:**  
Substantially Compliant

### **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:**  
Generally there were arrangements in place to safeguard residents and protect them from the risk of abuse. There was a safeguarding policy in place that had been updated



in line with the HSE National Guidelines. Staff spoken with were knowledgeable regarding types of abuse, indicators of abuse and the reporting structure in place should they have concerns or receive an allegation of abuse. While some staff at the centre had received a half day training on safeguarding (referred to as 'policy update training'), a number of staff had not received the provider's full day training on safeguarding prevention and detection.

Intimate care plans were in place for each resident and since the previous inspection these had been updated ensuring the specific needs of all aspects of residents' intimate care needs were outlined.

Positive behaviour support plans were in place for those who required them. The inspector reviewed one of these plans and found it offered clear guidance to staff in supporting the resident. The behaviour support plan had recently been reviewed and both proactive and reactive strategies were outlined. The resident's escalation and crisis phase was also clearly outlined in addition to the triggers of the behaviour. Staff spoken with were knowledgeable of the resident's behaviour support plan and the content of same. The behaviour support plan was also subject to a six monthly review which was up-to-date.

**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 inspector read incident records and was told by staff about incidents that occurred between residents. HIQA had not received notification of these incidents, in particular these related to incidents of peer-to-peer abuse

The person in charge stated all future notifications of such incidents would be notified as required by the Regulations.

**Judgment:**

Non Compliant - Moderate

**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:**

From a review of residents' personal plans it was evident that both long-term and short-term healthcare needs had been evaluated and accounted for. Records, reviewed by the inspector, highlighted a multidisciplinary approach. Residents had timely access to a general practitioner (GP) in addition to speech and language, occupational therapy, behaviour specialist, chiropody and psychiatry to name but a few.

Emerging needs regarding specific healthcare needs were documented, such as epilepsy. A log of appointments was also maintained for each resident outlining the nature of the appointment and the outcome of same.

Residents' nutritional needs were clearly documented in terms of 'eating, swallowing and drinking'. For those that were on modified diets it was outlined in their personal plan. Weight loss charts were used to observe weight loss; weight gain was also being monitored. Assessment tools such as the body mass index and the 'Malnutrition Universal Screening Tool' were used. Where required, staff had access to a dietician and speech and language therapist.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Overall, the inspector found that improvements were required in relation to the governance and management of the centre. The inspector found upon speaking with the person in charge that she had responsibility for two designated centres. Both centres supported residents with complex needs. The person in charge had commenced her role in this designated centre in the previous week. The person in charge was not supernumerary. Where there was an allocation of supernumerary hours she was unable to fulfil these as she was required to cover staff shortages and work in direct care. For example, on the day of the inspection and a few days previous she was allocated supernumerary days however she was working in direct care as rostered staff were unavailable. These arrangements did not facilitate the person in charge to have full oversight and accountability as required under her legislative remit. The provider had also failed to put in place arrangements for the person in charge to have oversight of staff working 24 hours a day seven days a week, in particular those staff who worked only nights. Arrangements were not in place for person in charge to oversee this; supervision of night staff was completed by a night sister.

The person in charge had not, at the time of inspection, received a full handover. As a result, the clinical nurse manager (CNM1) assisted the person in charge in the opening meeting of the inspection to answer questions regarding staffing, residents and the general running of the centre.

There were some systems in place to oversee the quality and safety of care. Audits were completed in a number of areas including medication, health and safety and clinical incidents. The provider also completed an annual review along with an action plan. The provider had also undertaken six monthly unannounced visits however, this had not occurred since September 2015.

Management of concerns raised by staff were not at all times robustly considered. The inspector read minutes where concerns regarding the staffing levels and the impact this was having on residents, both day and night, had been raised. These meetings occurred in January 2016 and May 2016, however at the time of inspection these concerns had not all been addressed. No additional staff had been assigned and staffing levels had further declined as staff had been redeployed out of the centre. There was no assessment of needs completed for the residents to support a reduction in their care and support needs. Resulting from the meeting in May 2016 a commitment to replace staff that were on long-term sick leave had been made.

**Judgment:**

Non Compliant - Moderate

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector met with a dedicated workforce who knew the residents well. Interactions between staff and residents were for the most part task-orientated but these were observed to be warm and respectful however, improvements were required. The inspector found that the staff numbers were not appropriate to meet the assessed needs of residents and the safe delivery of services. Staff did also not have up-to-date mandatory training.

The inspector read documentation, spoke to staff and completed observations all of which highlighted there were insufficient number of staff during the day at the centre. As outlined in Outcome 14, minutes pertaining to meetings where staff outlined their concerns regarding insufficient staffing levels were reviewed. The inspector spoke with staff who stated the centre was busy. The inspector read in residents' personal plans that goals being completed were dependant on staff availability.

The inspector completed a series of observations throughout the day where staff interacted, albeit warmly, with residents however, it was predominantly focused on task-orientated care such as assisting with showering, toileting and mealtimes. The lack of staff correlated with the lack of meaningful activity for residents throughout the day as highlighted in Outcome 5.

Six of the 13 residents, whom resided in the main part of the centre, required assistance with mealtimes; six residents required two staff to assist them with transfers and the use of a hoist and a large number of residents required assistance with toileting. During the day there were five staff on duty, this dropped to two staff at night-time. At night-time, six residents required the support of two staff to assist them to bed and complete their nightly routine of personal care. This on average totalled one hour and 15 minutes. While staff are assisting residents during this time, there is for the most part, no staff on the floor. Staff told the inspector that occasionally a third staff member may be available to assist but this was the exception rather than the norm. The inspector reviewed three weeks of rosters; there were only two staff rostered to work from 20:00hours onwards.

The staff at the designated centre also had additional responsibilities in terms of providing care and support to residents. In addition to the 13 residents whom received support, a resident not residing at the centre visited the centre twice a week for assistance with personal care. The inspector was told their needs have increased and they also require the support of two staff. The resident requires for example, two staff for approximately 45 minutes to shower. In addition to this resident, another resident whom is attached to the centre, and has their own core staff team also requires the assistance of a staff nurse each day, seven days a week, with the administration of medication. The provision of this additional support has an impact on the time available

to support residents with all aspects of their needs including their social care needs. Insufficient staffing levels were also identified on the previous inspection. No additional hours had been allocated, in fact staff had recently moved to another centre within the organization resulting in a reduction of 58.5 hours and the needs of the residents had increased.

From a review of staff training records it was evident that staff did not have up-to-date mandatory training in some areas. There were gaps for staff in terms of their safeguarding training as highlighted in Outcome 8. Staff also required refreshers on fire safety training and manual handling training.

**Judgment:**  
Non Compliant - Major

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

Ciara McShane  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



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

<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
<b>Centre ID:</b>	OSV-0003731
<b>Date of Inspection:</b>	08 June 2016
<b>Date of response:</b>	06 July 2016

### 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 05: Social Care Needs

**Theme:** Effective Services

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

A comprehensive assessment of needs had not been completed for all residents. In addition, residents' social care needs were not informed by the activity sampling.

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

**1. 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:**

A comprehensive assessment will be completed for each resident which will ensure that resident's social care needs are informed by the Activity Sampling. This has been completed on 31.12.2015. The PIC and the Key Worker will ensure each resident will be facilitated to engage in social activities of their choice that will provide each person with a more meaningful and fulfilled life.

**Proposed Timescale:** 15/09/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Goals that had been identified for residents were not at all times sufficiently detailed.

**2. 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:**

Once each resident's comprehensive assessment has been completed, monthly goals will be identified by the keyworker in conjunction with each resident. These goals will reflect the resident's assessed needs and will be evaluated on a monthly basis. All goals for residents will be reviewed by the key worker and will be tracked to monitor their implementation, updates on their progress or barriers. The PIC will ensure monthly audits are completed.

**Proposed Timescale:** 31/12/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The personal plans in terms of residents' social care needs had not been evaluated in terms of positive outcomes for residents.

**3. 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:**

A monthly audit of resident's social care needs will commence to assess the effectiveness of each goal with a view to positive outcomes for residents, considering changes and new developments. The PIC and PPIM will provide input to staff at unit meeting on 14.07.2016 to ensure all key workers are familiar with this process.

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

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

The low level of activation and social participation for residents did not maximise the residents' personal development.

**4. Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

PIC and P.P.I.M met with Day Activation Manager on 29/6/2016 and a plan is in place to develop and implement a comprehensive assessment which will outline supports necessary to maximise all residents personal development in accordance with their wishes. Residents goals will be reviewed and there will be a named keyworker to support the resident in their goal achievement. The PIC will liaise with the Nominee Provider where necessary for support.

**Proposed Timescale:** 31/12/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

As outlined in the body of the report a handrail in one of the bathrooms required repair.

**5. 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:**

This was discussed with the Maintenance Manager and it was agreed that the broken handrail be removed as it is no longer used by residents.



**Proposed Timescale: 06/07/2016**

**Theme: Effective Services**

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

1. Paintwork was required to the ceiling over a residents bed.
2. Areas required cleaning as highlighted during the inspection.

**6. 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:**

1. Paintwork has commenced and will be completed by 15.07.2016.
2. Areas of high cleaning have been highlighted to Maintenance Manager by written requisition and also verbally by PIC. This will be costed and completed by the end of July 2016

**Proposed Timescale: 31/07/2016**

**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:**

Although risks had been identified at the centre, risk assessments were not in place for all.

All risks were not reviewed at a minimum annually.

**7. Action Required:**

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

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

Risk assessments identified during inspection have now been reviewed and will be reviewed annually or sooner as required.

**Proposed Timescale: 06/07/2016**

## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

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

A number of staff working at the centre did not have the required training in the safeguarding of vulnerable adults.

**8. Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Staff identified as not having up to date training in safeguarding of vulnerable adults will be included in next training 27/7/2016 in conjunction with Social Worker.

**Proposed Timescale:** 27/07/2016

## Outcome 09: Notification of Incidents

**Theme:** Safe Services

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

Incidents of peer-to-peer abuse, in particular those that were targeted were not notified to HIQA.

**9. Action Required:**

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

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

P.I.C. will ensure all future notifications of such incidents will be notified as required by the Regulations.

**Proposed Timescale:** 06/07/2016

## 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:**

As outlined in the body of the report:

1. Arrangements were not in place to facilitate the person in charge to have oversight and accountability for the service provision 24 hours a day, seven days a week.

2. The person in charge was discharging her hours, for the most part, on the frontline over two designated centres. It was therefore unclear what arrangements were in place to ensure she could exercise her personal and professional responsibilities as outlined in the Regulations.

**10. 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 meeting took place with the PIC, PPIM, Director of Human Resources and Director of Client Services on 25th May 2016. This was to discuss concerns outlined by the PIC and her staff team. All concerns were discussed and minutes of the meeting are available for inspection. The Nominee Provider has commenced discussions with the PIC to support and work with her in ensuring she has the appropriate supernumerary time to carry out her role as PIC of the 2 designated areas and ensure the oversight and accountability for service provision 24 hours a day. A staff complement was discussed which will support the PIC with supernumerary time in each area. Also discussed if staff numbers go below the agreed complement a replacement is to be sought.

**Proposed Timescale:** 31/07/2016

**Theme:** Leadership, Governance and Management

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

Effective arrangements were not in place for the management of staff concerns.

**11. Action Required:**

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

The PIC highlighted staff concerns at a meeting with Director of HR and Director of Client Services on 25th May 2016.

- Staff complement discussed.
- The Nominee Provider, CNM3, PIC and PPIM will review present rosters to ensure the resources allocated to the centre are maximised to provide the most effective service that support each person to live a fulfilled life.

**Proposed Timescale:** 31/07/2016

**Theme:** Leadership, Governance and Management

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

An unannounced inspection had not occurred in the centre since September 2015.

**12. Action Required:**

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

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

The Registered Provider will ensure that unannounced inspections will occur in the centre once every 6 months or more frequently and put a plan in place to address any concerns regarding standard of care and support.

**Proposed Timescale:** 31/07/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The number of staff was insufficient to ensure all aspects of residents' needs were being met.

**13. 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:**

As per meeting of 25th May a number of actions were agreed with the PIC

- Staff complement discussed.
- Service user requiring support twice weekly is being reviewed with a view to an alternative location and support.
- The service user who is attached to the designated centre living arrangements are deemed unsuitable and is a service priority where an alternative appropriate living arrangement is being sought. The Nominee Provider has commenced team meetings around this resident's needs.
- The Nominee Provider, CNM3 , PIC and PPIM will review present rosters to ensure the resources allocated to the centre are maximised to provide the most effective service that supports each person to live a fulfilled life.
- PIC will ensure that up to date assessment of all service users needs will be completed.

**Proposed Timescale: 31/12/2016**

**Theme: Responsive Workforce**

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

Staff did not have up-to-date mandatory training in fire safety and manual handling.

**14. 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:**

Mandatory Fire Training has commenced for all staff and will be completed by 13.07.2016.

Staff identified as not having up to date manual handling will be prioritised on next available training dates. 10.08.2016 and 17.08.2016

**Proposed Timescale: 31/08/2016**