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:	Markree
Centre ID:	OSV-0002612
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Joanna McMorrow
Lead inspector:	Catherine Glynn
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
06 December 2016 10:15	06 December 2016 20:00
07 December 2016 08:00	07 December 2016 20:30

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

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

Summary of findings from this inspection

Background to inspection:
This was an unannounced inspection carried out to inform a registration decision. This was the first inspection of the designated centre following it becoming a standalone centre. This centre was formerly part of a larger congregated setting on a campus facility. The former centre has now become one of four designated centres as part of an overall reconfiguration plan in the Health Service Executive (HSE) in Sligo. The reconfiguration was established from the 30 of September 2016. The centre is a full-time seven day residential service for adults with an intellectual disability.

Previous inspections of the Cloonamahon Campus had identified a number of non-compliances resulting in meetings with the provider and the Authority issuing a

notice of proposal to cancel and refuse registration of the Cloonamahon Service. Following the notification the provider submitted representations setting out the improvements which had been made at the service since the last inspection, including the re-configuration of the campus from one designated centre into four.

How we gathered our evidence:
As part of the inspection the inspector met with 12 residents. Residents who spoke with the inspector stated they were happy at the centre and that staff were kind to them. The inspector observed staff interacting with residents who were unable to verbally indicate their satisfaction. The inspector observed that interactions were warm and respectful at all times. Residents were supported in accordance with documented care needs and staff communicated in the manner identified in communication assessments completed.

The inspector met with nine staff during the course of the inspection. This included the person in charge, the pharmacist, three nursing staff, maintenance staff and the provider. As part of the inspection the inspector reviewed documentation such as, 12 individual assessments and 12 person centred plans, medication records, maintenance records, incidents and accidents, risk register and policies and procedures.

Description of the service:
The provider had completed a draft statement of purpose at the time of inspection, as required by the regulations. This document outlined the care and support needs of the current residents in the designated centre. The centre was now a stand-alone designated centre. It had formerly been part of a larger campus setting which was now four designated centres.

The centre comprises two units which were located on the first floor of the facility. There were twelve residents, and the staffing compliment was reflective of the statement of purpose. There were sufficient communal rooms to accommodate the needs and choices of the residents in the centre. The inspector found that the living environment had been suitably decorated and furnished to meet the needs of the residents. There was further work on-going to ensure the planned maintenance of the premises was completed.

Residents had access to all areas of the overall building by a stairs or lift when required. Transport was available to assist residents to engage in activities in the community or to visit places of interest.

Overall findings:
The inspector found that the residents were supported and assisted to have a good quality of life. There had been improvement in the layout structure and fire systems in the centre. The recent reconfiguration in the management team resulted in positive changes in leadership and governance procedures in the centre.

Summary of regulatory compliance:
The centre was inspected against sixteen outcomes. The inspector found compliance in three outcomes: General Welfare and Development, notification of Incident's and

Absence of the Person in Charge. Six areas achieved substantial compliance: Communication, Admissions and Contracts, Safeguarding and Safety, Healthcare Needs, Governance and Management and the Statement of Purpose. Moderate non-compliance was found in five outcomes: Records and Documentation, Social Care Needs, Health and Safety and Risk Management, Safe and Suitable Premises and Resident Rights, Dignity and Consultation. Major non-compliance was found in Medication Management and Workforce.

The reasons for these findings are explained under each outcome in the report, and the regulations that are not being met are outlined in 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 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector found that actions from the previous reports had been completed; however, further improvement was required with regard to privacy and consultation.

There was a complaints policy and procedure in place, in the designated centre. This procedure was available in an accessible format. The name and photographs of the staff responsible for complaints were displayed in the centre. A nominated person for managing complaints was identified. This information was displayed in prominent areas in the designated centre. A record of all complaints was maintained, and the inspector found that there were no active complaints at the time of inspection. Staff were knowledgeable about the procedures for complaints.

Weekly meetings had occurred in the centre and a record was maintained of all that attended. Discussion around meal planning, snack choice, activities, social events and changes in the centre were recorded. Residents' choice was also reflected in their personal plans. This detailed the likes and dislikes of the residents and helped to guide staff with food choices and activity choices.

The inspector found that there were a number of residents sharing bedrooms on the day of inspection. Four bedrooms were listed as shared rooms in the statement of purpose. The inspector found that free-standing dividers were used to maintain residents' privacy and dignity during personal care. At all other times, no dividers were placed between beds. The inspector was advised that the dividers were unsafe for residents unless supervision was in place. The inspector found that not all residents' privacy needs were protected with the current facilities in place in the centre.

In addition, the inspector observed that there were no locks on the residents' bedroom doors. This meant that residents were not able to choose to have privacy if they required it.

The inspector found that personal property was recorded in an inventory log, held in the residents' personal plans.

Residents' finances were managed centrally by the accounts department. The inspector found improvement was required regarding maintaining the financial receipts for residents. During the inspection, the inspector found receipts that were stored incorrectly in the unit, for example in the medication trolley. Finance audits were completed throughout the year by the accounts staff. A record of all financial activity was kept in the centre. On review, the inspector found the staff were familiar with the procedures for managing residents' finances. On review of the finance activities, the inspector found that two staff signed for all transactions. The inspector met with the staff in the finance department as part of the inspection. The finance staff outlined the changes that would occur in the new year regarding a socialisation fund for all residents. This fund would ensure that their outings or activities were not limited by residents' personal income.

Information was available in the centre with regards to advocacy services. The inspector found that the person responsible was displayed in written and picture format in the designated centre. The inspector found referrals to advocacy in the residents' personal plans.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Overall, the inspector found that communication systems were in place in the centre; however, improvement was required in relation to access to Internet services in the centre.

On review of the personal plans, the inspector found that a complete assessment of the residents' communication ability was recorded and up to date. The plans outlined the residents' likes and dislikes with regard to their communication choices. There was

evidence of systems in use, for example, photographs, choice boards, picture exchange communication and modified sign language, which helped the residents in communicating their needs. The inspector observed staff communicating with residents in the manner that was identified in their plans, during the inspection.

The inspector found that there was access to televisions, radios and newspapers. However, the Internet was not accessible for all residents throughout the centre. The inspector was informed this was as a result of the Health Service Executive policy on security for internet access. Residents were able to use computerised devices in the day services. This was documented in their daily logs and enjoyment of this activity was recorded. On review of personal plans, a resident had identified purchasing assistive technology to enhance their communication needs as part of their goals identified.

Residents had access to telephone facilities when required throughout the centre.

Judgment:
Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
The inspector reviewed all 12 written agreements of care provided and found that they were all signed by residents or their representatives, in-date and held in the personal plan at the time of inspection.

The inspector reviewed the admissions process and found that no new admissions were being accepted in the centre. This was also reflected in the statement of purpose at the time of inspection.

There were no transition plans in place for residents, as no proposed moves were planned at the time of inspection.

In addition the inspector found that the written agreements of care did not clearly outline all fees to be met by the residents in the centre.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
The inspector found that, since the previous inspection, a comprehensive assessment of all residents' needs had been completed. Each resident had a detailed nursing assessment which was reviewed annually. These assessments guided staff on how to support residents with activities such as: personal care, activity choices, behaviour support needs, health care and medication management. However the inspector found that the residents' files were not provided in accessible formats. In addition, participation of representatives was not evident at the annual reviews.

The inspector reviewed all 12 personal plans at the time of inspection. From review, the plans were found to outline nursing interventions in line with the overall assessment of needs. These plans detailed dietary supports, behaviour supports and recommendations made by multi-disciplinary staff, for example, dietitian, speech and language therapist and general practitioner (GP). Risk assessments were also reflective of the assessed needs of the residents.

In addition to the nursing assessments, the inspector found that person centred plans were also in place for each resident at the time of inspection. These plans identified activities and goals for the residents. As part of the review, the inspector noted that a record was maintained reflecting the participants enjoyment of the activity, time spent and actions completed by staff to support the residents during the activity. In addition, photographs recorded the variety of activities completed by each resident.

The inspector found that goals were reflective of the residents needs, independent living skills and community engagement. Actions were outlined with steps in place to support and assist the resident in achieving each goal listed. There was also a record of completion and outcome for the participant. Residents were supported to access a range of community sports facilities, public houses, cafes, restaurants, religious events and active aging groups reflective of their needs.

Overall, the inspector found that since the last inspection, access to the community had increased and this was reflected in the logs of community outings maintained in personal plans. In addition, there was access to transport for the centre, with the buses provided or by public transport when required.

The inspector found that there was limited engagement with the multi-disciplinary staff in the annual reviews or the person-centred planning reviews. The inspector also found that residents or their representatives were not recorded as participating or attending review meetings.

The inspector found that while nursing assessments had been completed and were reflective of their needs or ability, they were not provided in accessible formats to the residents.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that work had commenced since the last inspection, to improve the overall facilities in the centre. However, work was still required to ensure all communal areas were reflective of the residents' needs.

As part of the inspection process, the inspector completed a walk around of all the facilities and units of the four designated centres on the Cloonamahon campus. During this process, the inspector met with the maintenance staff and received an update of all completed works and outstanding work at the time of inspection. A number of bathroom facilities were scheduled for further upgrade and this was reflective of residents' needs as identified by staff. For example, work on modified toilet facilities for persons with cognitive impairment and mobility issues was scheduled.

Since the last inspection, additional dining rooms had been provided for all residents. The dining rooms were suitably decorated and personalised for the residents. However the inspector found, that one kitchen was also used for office facilities and clinical equipment, which made the environment less homely. There was adequate communal

space for recreational and activity use in the centre; however, these were also used for storing equipment and medical supplies at the time of inspection.The inspector was informed, and had observed, that there were poor storage facilities throughout the designated centre. This impacted in the overall living environment for all the residents in the centre.

The inspector observed sitting rooms as well as additional rooms identified as relaxation rooms or sensory rooms.

Bathroom and toilet facilities were provided in the centre but they were also shared by residents from another designated centre on the campus. This reduced the availability of and access to toilets, for all residents. The inspector also observed the storing of laundry trolleys in toilet and bathroom facilities.

While decorating had occurred in the centre, the radiators, radiator covers and window sills had noticeable damage to their surfaces. The inspector also found that there was a lack of monitoring of all equipment used in the centre. There were no records provided outlining servicing or maintenance of equipment in use at the centre, for example, glucometers and wheelchairs.

The inspector found that personal storage was also limited throughout the centre. The inspector also found that where there were two people sharing or one person occupying a bedroom, the storage space remained the same. The inspector also found that personal belongings were stored in other areas of the centre, for example, toiletry bags were not separated or stored individually in communal places.

The inspector found that residents' bedrooms were suitably decorated and personalised. The inspector observed flooring being replaced at the time of inspection, which improved the residents' living area.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
The inspector found that there was improvement in the centre with regard to risk management and fire safety; however, further improvement was required to

outstanding fire safety improvements. There was a noticeable change to the layout of the centre with the addition of fire doors and compartmentalisation of the centre.

The inspector found that two actions remained outstanding from the previous inspections: fire procedures were not displayed in the designated centre at the time of inspection and there were staff that had not completed fire training.

Review of training records showed that not all staff had fire training. Staff spoken with were familiar with the fire procedures and outlined the steps they would take to assist the residents move away from the fire based on the centre's horizontal evacuation plan. Fire records showed that drills had occurred weekly and with the minimal amount of staff to identify learning. All residents had an individual evacuation plan in place, which clearly outlined the care and support each resident required in the event of an evacuation. Emergency equipment such as evacuation sheets and wheelchairs was listed in the evacuation plan.

The inspector observed the laundry practices in place at the centre, and was also informed by staff that there were procedures in place for the management of soiled linen and clothing. This prevented cross contamination for residents. A centralised laundry facility was in place for all linen at the centre. In addition there was also a laundry service on campus for the residents' clothes. Equipment such as waste disposal, aprons, gloves, hand sanitizers and sharps bins was provided throughout the centre.

Staff knowledge of infection control practice was reflective of the policy and procedures in place at the centre; however review of the training records showed that not all staff had completed hand hygiene training as required by the provider's policy.

The inspector observed and reviewed documentation that outlined the most recent up-grade to fire safety in the centre. There were fire doors located in all communal areas of the centre. These doors were also linked to the alarm systems. All doors had self closures and intumescent seals. Fire panels were located in communal areas of the centre. Fire extinguishers were located in the centre. The inspector found that further work was commencing post-inspection with the installation of additional emergency lighting as the current lighting was inappropriately placed with the compartmentalisation in place. However additional smoke detectors would not be installed until the following year due to budgetary restraints. In addition, the fire displays were not clearly displayed in all areas of the centre since layout was modified.

The inspector found that the maintenance staff coordinated the fire drills on a weekly basis. This identified any problems with coding or failure in the systems that needed further work, for example, the incorrect information display regarding rooms or numbering on the fire panel. A record of all drills was maintained, with a receipt printed from the main panel to confirm this detail. The inspector found that room numbers were identified on the fire panel, but there were no numbers on bedrooms throughout the centre to help identify the location of a fire.

The fire system records showed that all equipment was serviced regularly by an external contractor. Staff also checked the fire systems on a weekly or monthly basis. However, fire doors were not checked on a weekly basis as part of the systems records.

The centre had an individual risk register completed. This risk register outlined all identified risks and the control measures that were in place to support residents and staff. For example, staff training in fire safety and infection control. Staff knowledge of the risk register was reflective of the current risk assessments completed.

The inspector found that on review of the risk register, the provider had not updated the risk ratings after control measures were implemented. For example, staffing levels had been at a red risk rating in July and, after review, remained at red in December even though the staffing complement in the centre was not a cause of concern at the time of inspection.

The risk register did not reflect all risks identified in the centre, such as the storing of oxygen cylinders in communal living areas. Furthermore the inspector observed wheelchairs and a hoist being stored along a hallway designated as a fire exit route.

The inspector found that oxygen cylinders were not stored in line with organisational policy. The inspector found that there was a communal storage area that did not secure all cylinders. There was no separation of used and new cylinders observed by the inspector. In addition, the inspector observed that the supplies were stored outside and risk of infection was not adequately prevented with the current storage procedures. This was brought to the providers attention during the inspection.

A record of all incidents and accidents was maintained at the centre. The incidents recorded were maintained and discussed at staff meetings. They were also reviewed at a risk management review meeting. All incidents were also logged in personal plans.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
The inspector found that systems were in place to support and protect residents from

abuse and behaviours that concern in the designated centre at the time of inspection.

There was an up to date policy in place regarding the prevention, detection and response to abuse. On review of the training records all staff had completed safeguarding training. Staff spoken to were familiar with, and understood, how to recognise signs or symptoms of abuse. Staff were clear about their response to any concerns or suspicion of abuse and were knowledgeable about the reporting structures in place. Information was displayed throughout the centre identifying the nominated designated safeguarding officer, and a photograph was also displayed to assist the residents to recognise the person responsible.

Intimate care plans were kept in the personal plans. These detailed all the care and support needs of the residents. These plans were up to date and staff were familiar with the guidelines in place.

The inspector found that any allegations of suspected abuse had been notified to the Health Information and Quality Authority (HIQA) in line with the regulatory requirements. Where incidents were reported, there was documented follow up in the personal plan, outlining all actions completed, to ensure the residents were monitored and supported with additional multi-disciplinary input, where required.

The inspector found that all residents with behaviours that concern, had a positive behaviour support plan in place. This detailed the care and support needs of the resident. In addition, there was evidence of multi-disciplinary support with the input of psychiatry, behaviour support therapists and psychology, where required. All positive behaviour support plans were in line with the organisations policy and national policy. The plans reviewed outlined the triggers and strategies identified to support the residents during periods of behaviours that concern. These plans were reviewed regularly, and staff were familiar with the plans.

On review of training records, not all staff had completed positive behaviour support training as required by the provider's policy.

The inspector found that there were no restrictive practices in place at the centre, however staff informed the inspector that any such practice would be discussed at multi-disciplinary level. The representatives of residents were also invited to engage in meetings about restrictive practices when required. The staff also outlined that the local policy regarding restrictive practice was to ensure that any practice was a last resort and for the shortest time possible.

The inspector observed staff interactions with residents and found that they were warm and respectful and reflected the residents' assessed needs.

Judgment:
Substantially Compliant

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

Findings:
The inspector found that the centre had submitted notifications to the Chief Inspector as required by the regulations.

Since the previous inspection, a review of all notifications submitted to the Health Information and Quality Authority (HIQA) was conducted. The inspector reviewed accident and incident logs in the centre and found that all notifiable events had been submitted as required within the appropriate time-frames.

The inspector found that the person in charge and the provider were aware of their responsibilities with regard to reporting and recording all notifiable events in the designated centre.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
The inspector found that residents were supported to access and engage with their local community.

Since the previous inspection, the inspector found that there had been improvement regarding accessing the community. This was reflected in the personal plans and nursing notes. Weekly activity records were kept and levels of engagement and satisfaction was recorded.

There was a day programme facilitated on the ground floor of the campus building. This provided various activities in line with the assessed needs of residents. Community activities explored included meals out, music events, active aging groups and religious activities. There were photographs kept of group outings to local places of interest, such as beaches and sporting events.

The inspector found that residents' were supported to maintain links with family and friends through trips home and day visits. Records of all family engagement were maintained in the personal plans.

The centre had a policy in place regarding access to education, training and development for residents.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Overall, the inspector found that the residents were supported to meet their health-care needs in the centre.

The inspector found that a comprehensive assessment had been completed with regard to healthcare needs. Interventions were outlined to guide staff to care and support the residents. Medical needs were met, when required, by a General Practitioner. On review of personal plans and health records, the inspector found that details of blood tests were maintained. There were referrals to allied health services when required, such as dietitian, occupational therapists, chiropodists and dentists. Records of residents' health were maintained, such as vital signs and weight monitoring.

The inspector reviewed reviewed assessments for residents that had epilepsy and found that protocols were in place which outlined the care and support needs in the event of a resident requiring emergency medication.

On review of health records the inspector found that two residents were prescribed a blood thinning medication. The inspector found there were no protocols in place for the residents requiring this medication. A support plan was not in place to ensure that staff were informed about the care and support needs of the residents' on such medication.

This was not in line with the national policy in relation to medication management. Nursing staff spoken with were aware of the care and support needs but this was not documented in the health care notes.

Residents were supported to purchase and prepare snacks of their choice in the kitchens provided in the centre. Pictorial books were used to assist all residents, where required, to make their choices known to staff at weekly meetings. Facilities had been allocated to ensure that staff were able to support the residents with snacks, for example, toasters, liquidisers, a kettle and a microwave.

The inspector found that where residents had specialist dietary needs, input from a relevant health specialist was recorded in the health care notes. Speech and language therapist (SALT) assessments regarding food consistency was evident in the centre. Dietitian support was also recorded, with plans outlined regarding weight management and assessment. There were on-going reviews of dietary needs and support available when required. All dietary supplements were prescribed and included in the medication administration sheet.

Judgment:
Substantially Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
On review of all medication storage facilities in the designated centre, the inspector found there was evidence of poor governance with regard to auditing and monitoring of medication stock control.

The inspector found that one action remained outstanding from the previous inspections. The action related to centre specific policy to manage storing, stock control and administration of medicines.

The inspector found that the current practice was a two weekly ordering system. Every two weeks, the staff nurse completed an order of required supplies. This was then submitted to the local hospital pharmacy and then delivered. The delivery was always checked by the nurse on duty. However the inspector observed that stock for items such as pain relief were in excess of requirement for a two week period. This was confirmed

by the pharmacist.

The inspector also found that miscellaneous items were stored in the medication locked trolley, for example receipts, money, a digital camera and first aid items. This was not in line with best practice or local procedures. In addition, the inspector found that there were no audits completed of medication facilities or procedures in the centre.

A pharmacist completed a clinical review with the psychiatrist on a periodic basis. This involved a detailed review of medications prescribed, diagnosis and presentation of residents. A record of this was held in the medication file.

The inspector found that controlled medications were in use in the designated centre. Nurses spoken with were familiar and informed of the required recording and stock control measures for such medications. The inspector reviewed records and found that there was a record of drugs administered and this matched the current stock held. Controlled drugs were signed by two staff at the start and end of each shift in line with national and local policy. The drug administration sheet also reflected the product in use, and the personal plan specified the care and support needs for the resident.

The inspector found that there was a communal medication storage area in the overall campus. This held products such as antibiotics which were used in the event of out-of-hours need. The inspectors found that medications were stored with other medical supplies such as dressings and syringes. The inspector also found that the antibiotics held were past their expiry date. There was no system in place to ensure safe and effective stock control measures were in place at the time of inspection. As a result, an immediate action was issued to the provider, which required removal of all expired products and a review of the current procedures in place for effective medication management systems.

The inspector found that residents were assessed in relation to self administration of medication where required. At the time, of inspection all residents in the centre required the support of nursing staff with regard to medication administration.

The inspector found that medication sheets continued to be inconsistent in practice, for example, the prescribing of a child's medicinal product was outlined in one sheet but in another medication sheet this direction was not specified.

The inspector met with the pharmacist during the course of the inspection and was informed of changes in procedures, with the addition of a pharmacy technician based in the four centres two days a week. This would improve all stock control and ordering practices in the centre.

The inspector found that residents were not afforded choice regarding their pharmacist or service provided. There was a centralised practice in place which was linked to the local hospital.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
The inspector found that the statement of purpose was not in line with schedule 1 of the regulations.

The centre had provided a draft statement of purpose as it was now a standalone centre within the original campus. There was an accessible format of this document which was known as 'my guide' about the services and facilities available in the centre.

The draft statement of purpose did not outline all the requirements of schedule 1, for example a description of all rooms available in the centre with the size, dimensions, layout and purpose of each room.

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

Findings:
The inspector found that the governance and management arrangements had changed since the last inspection. This change was also in line with the recent reconfiguration of

the previous service. The centre was now a standalone centre.

The statement of purpose provided to HIQA, was reflective of the service provided post changes. More importantly it outlined the new management structure that was in place in the centre. The inspector found that the person in charge was in post at the time of inspection and worked full-time. The inspector found that this person was knowledgeable of their position and the responsibility it entailed. The inspector found that the person in charge was known to all twelve residents and staff in the designated centre. She had worked in the original centre for a number of years and had been part of the changes that had occurred organisationally.

Staff spoke about the changes in management structure in a positive manner. They stated that the person in charge was accessible and had knowledge of practice to support them in their role. In addition, while no formal support was in place at the time of inspection, staff stated that they could meet or speak with the person in charge on an informal basis. Team meetings were held regularly and set out actions required with persons responsible to complete tasks.

The inspector spoke with the person in charge and found that she had an understanding of her role, knowledge of the needs of residents and knowledge of the regulations. During the course of the inspection, the person in charge was forthcoming and transparent with all aspects of the inspection process.

The person in charge had undertaken all relevant training as set out by the provider and had a keen interest in continuing their personal development through further education, as part of the HSE management strategy.

The person in charge had completed audits which involved personal plans, person-centred plans and health and safety issues.

The inspector found that an annual review had been completed and was located in both units in the centre. The inspector found that no six monthly unannounced visits had been completed in the newly reconfigured designated centre. The last six monthly audit had been completed during July 2016, when the centre was part of the previous designated centre and by the previous provider.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The inspector found that the provider was aware of their responsibility to ensure effective systems were in place in the event of the absence of the person in charge. This was also reflected in the statement of purpose.

The inspector found that staff were knowledgeable of the arrangements in place in the event of the absence of the person in charge for more than 28 days. Since the centre had become a standalone centre, no record of absence of the person in charge had occurred.

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
The inspector reviewed the rotas, staffing records and staff files at the centre following the findings from the previous inspections at the centre. There were gaps in the training records, of staff and the staff files were not in line with schedule 2 of the regulations. One action remained outstanding since the previous inspections with regard to training needs for staff.

The centre had planned and actual rotas in place. The rotas were reflective of the needs of residents, and additional supports were available when required, as identified on the rota. The staffing structures in place were reflected in the statement of purpose. There were two nurses and four care assistants on duty on a daily basis to meet the needs of the 12 residents.

Team meeting minutes were held in each unit in the centre. A record of attendance was kept and all staff had the opportunity to participate. Items discussed included training

needs, health and safety and care and support needs of residents. All staff spoken with outlined the improvements since the last inspections, specifically, the access to transport arrangements for social outings and new management structures in the centre.

On review of staffing files, the inspector found that there were gaps in records held at the centre. The staffing files were not in line with schedule 2 of the regulations in relation to the following areas:

-vetting disclosures in accordance with the National Vetting Bureau(Children and Vulnerable Persons) Act 2012
-copies of qualifications
-contracts of employment
-full employment histories, including any gaps in employment.

The inspector found that a training needs analysis had not been completed since the last inspection. However, a training record of all staff working in the centre was maintained. The inspector found that this training was based on mandatory training such as manual handling, safeguarding and positive behaviour support, as reflected in the statement of purpose. At the time of inspection, the inspector found that there were gaps in the training records, as not all staff had completed training in the following areas:

-hand hygiene
-medication management
-fire safety
-positive behaviour support.

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):
No actions were required from the previous inspection.

Findings:

The inspector found that the centre had not ensured all documentation was in line with the regulations at the time of inspection.

A comprehensive review of all documentation required by the regulations was completed at the time of inspection following the previous inspection findings.

The policies and procedures required under schedule five of the regulations had not been maintained as required. For example:

- there was no date of completion or review for, residents' personal property, finances and possessions records
-recruitment, selection and vetting of staff had exceeded the three year review period
-complaints procedures were out of date
-the closed-circuit television policy did not have an approval date but did have a revision date.

The directory of residents was held at the centre; however, the inspector found that this was not in line with the requirements of regulation 19 of the Health Act 2001 (Care and Support of residents in designated centres for persons (Children and Adults) with Disabilities) regulations 2013.

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:

Catherine Glynn
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002612
Date of Inspection:	06 and 07 December 2016
Date of response:	20 January 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The privacy of residents was not maintained where shared bedrooms were in place:

-Bedroom doors could not be locked
-Privacy screening in shared bedrooms did not reflect the residents' needs.

1. Action Required:

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

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

Please state the actions you have taken or are planning to take:
• Thumbturn locks will be placed on all bedroom doors to ensure privacy for all residents.
• Free standing dividers will be removed in all shared rooms
• Curtains will be placed into all of the 4 shared bedrooms which will surround each bed individually to ensuring privacy and dignity for each individual resident. All staff will continue to uphold and ensure the privacy and dignity at all times.

Person responsible: PIC

Proposed Timescale: 28/02/2017

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not maintaining receipts in a safe and secure manner for residents.

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

Please state the actions you have taken or are planning to take:
• Residents will continue to be supported to manage their finances as outlined in their personal plan.
• Staff in the centre will retain and manage receipts in a safe and appropriate safebox in each area in line with the HSE financial regulations and policy.

Person Responsible: PIC

Proposed Timescale: 20/01/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have access to internet services in all areas of the designated centre.

3. Action Required:

Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

Please state the actions you have taken or are planning to take:
• A full review with the HSE IT Department, general manager and the provider of internet access within the centre will be carried out to find suitable means of accessing the internet for use by the residents.

Person Responsible: Registered Provider

Proposed Timescale: 28/02/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Written agreements of care did not clearly outline all fees that would be met by the residents.

4. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
All contracts will be reviewed and updated to include and outline all fees charged to the residents in line with regulations.

Person Responsible: PIC

Proposed Timescale: 31/01/2017

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:
Personal plans were not available in an accessible format for residents.

5. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their

representatives.

Please state the actions you have taken or are planning to take:
• The person in charge in consultation with the speech and language therapist is in the process of developing an appropriate accessible personal plan for each individual resident or their representative. This accessible format will be dictated by the individual communication needs of each resident as identified in the individual communication passport. The resident will be fully involved in the process where appropriate.

• A computerised communication symbol system has been ordered for the centre which will enable staff to convert all relevant documentation into accessible format for the residents and/or their representative.

Person Responsible: PIC

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector found that not all residents or their representatives participated in review meetings.

6. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
• A Schedule of reviews of personal plans has been formulated and will involve all residents and/or their representative if they so wish.
• All residents or their representative, where appropriate will be involved in review meetings, and all aspects of their care.
• All records of family involvement will be recorded in their personal plan.

Person Responsible: PIC

Proposed Timescale: 31/01/2017

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 inspector found that parts of the centre were in a state of disrepair:

-bathroom facilities.
-toilet facilities
-furnishings that were damaged and worn

7. 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:
A comprehensive review of all maintenance to be completed in the centre has been under taken by the PIC and maintenance supervisor, and a planned schedule has been put in place to include refurbishment of bathroom facilities, replacement/repair of radiators or radiator covers and damaged window sills.

Person Responsible: PIC & Registered Provider

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that a log was not kept of all repairs or maintenance for all equipment provided to assist residents.

8. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
• Maintenance log to be held in designated centre outlining all equipment in use and dates of repairs and maintenance required

Person Responsible: PIC

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that the centres layout and facilities was not in line with the requirements of schedule 6 of the regulations:

-there was inadequate storage facilities throughout the centre, in communal living space and in residents' bedrooms.
-there were insufficient bathrooms and toilet facilities to meet the needs of residents'
-living space was also being used as storage areas for medical equipment and excess equipment, such as wheelchairs.

9. 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:
• Conversion of 2 areas in the designated centre will provide 2 extra bathing facilities for the 12 residents in the designated centre
• Suitable storage will be identified in the designated centre for medical equipment, wheelchairs and all equipment will be removed from the living space.
• Additional storage will be provided in the shared bedrooms to meet the needs of the resident.

Person Responsible: Registered Provider & PIC

Proposed Timescale: 31/03/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centres risk register did not;

-contain all risks identified in the centre
-was not up-to-date with controls in place in the centre

10. 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 register will be updated for the designated centre to reflect all identified risks in area and current controls in place to support the centre.

Person Responsible: Registered Provider & PIC

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inappropriate storage of oxygen cylinders did not ensure the prevention of cross contamination to staff and residents in the centre.

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

Please state the actions you have taken or are planning to take:
• The policy on oxygen administration and storage will be reviewed and updated ensuring it is centre specific
• Schedule of cleaning of oxygen cylinders prior to transfer to the centre is now in place to reduce the risk of cross contamination
• Appropriate safe and suitable storage facilities for oxygen cylinders has been ordered.

Person Responsible: Registered Provider & PIC

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient emergency lighting in place in the centre.

12. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
• Additional emergency lighting has been installed all areas of the designated centre to include all additional areas following compartmentalisation works.

Proposed Timescale: 16/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient smoke detectors in the centre at the time of inspection.

13. Action Required:

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

Please state the actions you have taken or are planning to take:
• Contract has been secured for the installation of additional smoke detectors and the work is due to commence on the 16.01.2017 with an expected 5 day completion.

Proposed Timescale: 20/01/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire evacuation plans and simulated drills did not include arrangements for a comprehensive and full evacuation of the premises.

14. 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:
• A Schedule of simulated fire drills is in place to include vertical evacuation plans for all residents from the premises

• All peep plans have been reviewed to include plan for full evacuation of the premises.

Person Responsible: PIC

Proposed Timescale: 31/01/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no record of maintenance of all equipment and facilities in the centre.

15. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
• Fire door checks will be conducted at regular intervals in line with the provider's own fire safety arrangements, as per Fire Register Documentation.
• In addition a weekly fire checklist will be completed in each designated centre.

Person Responsible : PIC & Registered Provider

Proposed Timescale: 10/02/2017

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:
Not all staff had completed positive behaviour support training.

16. 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:
• All staff within the designated centre have completed training in the management of behaviours of concern and de-escalation and intervention techniques.
• Schedule of training in place for the year to include any staff currently on leave and any staff requiring refresher training

Person Responsible: PIC

Proposed Timescale: 31/01/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Protocols were not in place for all residents requiring blood thinning products.

17. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
• Support plan has been developed in conjunction with pharmacist and GP for each resident using blood thinning medication.

Proposed Timescale: 23/01/2017

Outcome 12. Medication Management

Theme: Health and Development

The Provider is failing to comply with a regulatory requirement in the following respect:
Medication stock control measures were not in place in the centre, such as expiry dates and monitoring of stock levels.

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

Please state the actions you have taken or are planning to take:
• All staff nurses working in the centre have been advised to complete medication management course on HSE land and submit their certificate to the PIC by 31.01.2017
• Stock control checklist in place to manage stock in the centre and procedures in place in line with the policy for the returning of excess stock if necessary
• Medication audit completed by PIC 13.01.17 and a QIP in place.

Person Responsible: PIC

Proposed Timescale: 08/12/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider did not ensure that out of date stock was segregated from in-date medications in the communal medication storage area.

19. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
• All out of date medication is returned and stored in line with medication management policy
• All staff nurses working in the centre have been advised to complete medication management course on HSE land and submit their certificate to the PIC by 31.01.2017
• Checklist in place in all area
• Medication audit completed by PIC on 13.01.2017 and a QIP in place.

Person Responsible: PIC

Proposed Timescale: 31/01/2017

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that residents were not offered choice regarding their pharmacy service.

20. Action Required:
Under Regulation 29 (1) you are required to: Ensure that a pharmacist of the resident's choice or a pharmacist acceptable to the resident, is as far as is practicable, made available to each resident.

Please state the actions you have taken or are planning to take:
• All residents are currently supported to access the current pharmacy service offered in the centre.
• Local pharmacies will be explored to discuss the pharmacy requirements of the residents and services available in the local community in conjuction with the specific needs of the residents.

Person Responsible: Registered provider

Proposed Timescale: 16/03/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not contain all the requirements of schedule 1.

21. 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 include all requirements set out in schedule 1 of the Health Care Act 2007

Person Responsible: PIC

Proposed Timescale: 31/01/2017

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:
There was no six monthly unannounced visit completed in the newly reconfigured designated centre.

22. 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 provider has a schedule of 6 monthly unannounced visits in place and these visits have commenced on the campus and these will take place at least once every 6 months. The provider will provide a written report on the safety and quality of care and support in the designated centre and any concerns will be addressed in a QIP.

Person Responsible: Registered Provider

Proposed Timescale: 30/06/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff files were not in line with schedule 2 of the regulations.

23. 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 to include all information outlined in Schedule 2. A index page will be included in each file outlining the relevant documentation necessary for each file.

Person Responsible: PIC

Proposed Timescale: 28/02/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector found that not all staff had up-to-date training in:

-medication management
-hand hygiene
-positive behaviour support
-open disclosures
-fire safety

24. 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:
Training schedule for the coming year is in place in the designated centre to ensure all staff have up to date training.

• Medication management: all nurses have been advised to complete medication management on HSEland and submit certificate by 31.01.17
• Hand Hygiene: all staff have access to hand hygiene on HSEland
• Positive Behaviour Support: all staff in the centre are up to date with positive behaviour support training, training plan in place for the year to include refresher training required and staff on current leave.
• Open disclosure: dates for upcoming training 25.01.17 & 01.02.17
• Fire safety: 100 % of staff in designated centre have up to date fire training

Person Responsible: PIC

Proposed Timescale: 31/01/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies had not been reviewed within a three year time frame.

25. Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at

intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
• A comprehensive review of all policies and procedures under Schedule 5 will be undertaken and all policies will be reviewed as necessary to meet requirement.

Person Responsible: Registered Provider

Proposed Timescale: 30/06/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents' did not contain all the information required as set regulation 19.

26. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
• All directory of residents have been updated for all 12 residents in the centre to reflect and include all information outlined in Schedule 3 of the Health Care Act and are updated as necessary.

Person Responsible: PIC

Proposed Timescale: 20/01/2017