Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Kilcummin Accommodation
Centre ID:	OSV-0005231
Centre county:	Kerry
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Provider Nominee:	Rachael Thurlby
Lead inspector:	Kieran Murphy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
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 following receipt of unsolicited information. 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:
05 January 2017 14:00	05 January 2017 18:00
06 January 2017 09:00	06 January 2017 15:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the second inspection of a centre that was registered as a designated centre with the Health Information and Quality Authority (HIQA). The centre was managed by Rehab Care Services who provided a range of day, residential and respite services throughout Ireland.

It is a requirement of the regulations that all serious adverse incidents, including allegations of abuse are reported to HIQA. 17 safeguarding incidents had been submitted to the Chief Inspector since April 2016. In response Rehab Care service had reviewed their processes and introduced systems to ensure residents were safe.

In addition, prior to the inspection unsolicited information had been submitted to HIQA relating to the centre. While HIQA does not have the statutory remit to investigate individual complaints, the information received was used during the inspection to seek reassurance from the provider of services around the quality and safety of care in the designated centre. The issues identified had been resolved by the date of the inspection.

Description of the service:

The centre is a detached house on the outskirts of a small town. The centre opened

in September 2015 and it provides a home to four residents who require varying levels of support. All four residents had been living in the centre since it opened and each had previously lived in a congregated setting. There was evidence that the transition for these residents had taken place in a planned and safe manner.

All of the residents attended a day service that was appropriate to their needs. The person in charge outlined each day service incorporated a lifeskills training programme. This was also supported in the centre with independent living skills and home activities to equip residents with the skills to manage their home including finances and shopping and also how to access activities in the community.

How we gathered our evidence:
The inspector met with the four residents living in the centre. The inspector also observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

The inspector met with the house team leader, five staff members, the regional manager of Rehabcare and the person in charge (service manager). The inspector observed staff interaction with the residents and it was noted that staff had good knowledge of each resident's individual needs and were seen to support residents in a respectful and dignified manner.

Overall judgment of findings:
There was evidence of good practice. Each resident was supported to use local services such as leisure and restaurant facilities. During the course of the two day inspection each resident had either gone shopping in town or had been to lunch in a hotel for "women's little Christmas". Residents had also organised a mass to be said to bless the house, with families, friends and neighbours scheduled to attend, One resident told the inspector "I am really looking forward to having a great night".

Positive relationships between residents and family members were supported. A number of residents spent weekends and holidays with family. One of the residents said "my family collects me to take me home and sometimes they come and see me here". A number of families had responded to RehabCare survey that had been completed recently. The families stated that there had been a strong improvement in the quality of life for residents since moving to this community based residence.

However, some improvement was required to the resident's personal planning process to ensure that all their needs continued to be identified and met. Improvement was also required in relation to the management and ongoing review of risk on the centre risk register. A number of administration errors were also noted on one resident's administration record.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end of this report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 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):
No actions were required from the previous inspection.

Findings:
Each resident had been well supported to transition to this community based residence from a congregated setting. There was evidence that each resident's social care needs were being met. However, some improvement was required to the residents personal planning process to ensure that all their needs continued to be identified and met.

All four residents had been living in the centre since it opened and each had previously lived in a congregated setting. There was evidence that the transition for these residents had taken place in a planned and safe manner. Residents were supported to maintain contact with their friends and staff from their previous home; and on the day of inspection one resident was writing a card to a former staff member inviting them to visit.

Each resident attended a day service which was appropriate to their needs. One of the residents had recently changed their day service provider and now accessed a day service that was closer to her current home.

There were three sets of resident records: the person's support plan, the "service user file" and a separate file for medical records. In the person support plan there was a summary profile of the resident which outlined things that staff and carers must know about the resident; a summary of multidisciplinary healthcare issues; and it included issues that were important to the person like medication, communication and eating.

The inspector reviewed residents' personal plans and found that where residents had communication needs, this was captured in personal plans. There were specific

communication boards for some residents detailing picture schedules as recommended by the speech and language therapist. There was also a staff rota picture board. These communication boards were used to give certainty to residents about what was planned for the day and which staff were on duty.

In addition there were "social stories" in place for a number of residents. The social story was a visual guide that described a situation, skill, or concept in terms of relevant social cues, perspectives, and common responses in a specifically defined style and format. The goal of the social story was to share accurate social information in a patient and reassuring manner that was easily understood by the resident. One example of a social story that was being used was around the issue of safeguarding and 'staying safe' and it was discussed with residents at house meetings.

In relation to social care needs there was evidence that each resident was supported to develop an individual lifestyle plan each year with input from the resident, family members, friends, and the transition coordinator from the previous service provider. At this planning meeting various issues were discussed and in particular things that the resident liked to do. However, the process for person-centred planning and goal setting required improvement. In particular, it was not identified what supports the person needed to achieve the things they liked to do and also there was not a timeframe identified for the person to achieve their goals.

In relation to healthcare needs there care plans had been developed for identified healthcare needs. These care plans were in the person centred planning folder. The supplementary information in relation to these healthcare needs was in the separate file for medical records. Staff outlined that they accompanied residents to healthcare appointments either with a general practitioner or a consultant doctor. The person in charge outlined that following such a healthcare appointment staff recorded the outcome of the appointment. However, the resident's personal plan was not always accurately updated following these appointments.

The personal planning process was not the subject of a multidisciplinary annual review as required by the regulations. Therefore the process did not address the supports that may be required from other healthcare professionals that would best meet the resident's needs using combined strategies.

There had been some admissions to hospital by residents in the last 12 months. However, there was no information on file in relation to these hospital admissions. In particular an assessment of residents' health needs had not been completed and their care plan had not been updated to reflect the instructions of the discharging hospital team.

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):
No actions were required from the previous inspection.

Findings:
The health and safety of residents, visitors and staff was promoted and protected. Some improvement was required in relation to the management and ongoing review of risk.

The inspector reviewed the incident reporting system from January 2016 to December 2016. Of the 146 incidents seen, 52 related to incidents of violence and aggression and 41 related to incidents of residents falling. 36% of the recorded incidents from 2016 seen by the inspector were related to physical or verbal assault.

This included:
• 33 incidents of verbal abuse of staff or residents by another resident
• 12 times where staff or residents were struck by another resident
• 6 occasions where a resident required support to manage their behaviour

There was a system in place to ensure that all incidents were followed up by the person in charge and were reported to senior management of the service at a regional level to review for trends.

There was a risk management policy that included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. Each resident had participated in identifying specific hazards relating to their lives, for example using a wheelchair, cooking or community access. These were contained in an individual risk management plan that put clear strategies in place to address the hazards.

The centre had a risk register in place. A centre risk register is designed to log all the hazards that the centre is actively managing. The centre’s risk register had four issues included, all of which were assessed as being at a low risk:
• supporting people who do not have an awareness of safety
• supporting people who may engage in self injurious behaviour
• violence and aggression
• accidental injury.

The person in charge and the regional manager explained how specific issues were escalated from the centre to senior management of Rehab Care. However, these risks were not always recorded on the centre risk register. For example, there had been an issue with staff vacancies that had been escalated to senior management and resolved but it had not been managed via the risk register.

There were other issues that needed to be included on the risk register but were not on it, for example access for residents to a dietitian for 2017. In addition, the risk register

did not reflect the hazards identified through the incident reporting system. For example, a risk assessment in relation to “behaviours that challenge” had a risks rating of 12 (medium risk). However, on the risk register this was recorded with a rating of 2 (low risk).

The inspector saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:
• servicing of fire alarm system and alarm panel November 2016
• servicing of emergency lighting system October 2016

Each resident had a personal emergency evacuation plan which outlined what assistance, if any, the resident required in the event of an evacuation. There were records of evacuation drills being carried with the most recent being in December 2016. All residents spoken with knew what to do in the event of a fire, including the evacuation routes and assembly points. There were fire doors available throughout the building; and there was emergency signage identifying escape routes. There was daily checking of the means of escape routes.

There was a policy in relation to control and prevention of infection and the centre was visibly clean. Standard universal precautions were in place in relation to the disposal of clinical waste and staff spoken with were aware of infection control principles. However, it was noted that hand drying facilities were not available in the staff office and staff were observed washing their hands in the office and drying them elsewhere.

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:
There was evidence that all serious adverse incidents including allegations of abuse had been appropriately investigated and resolved. Residents were also supported by positive approaches to behaviours that challenge.

It is a requirement of the regulations that all serious adverse incidents, including allegations of abuse are reported to HIQA. 17 safeguarding incidents had been submitted to HIQA since April 2016. Following receipt of these incidents HIQA requested RehabCare service to undertake a review of their processes to ensure residents were safe from abuse.

A full review had been undertaken with input from the designated officer, social work team, psychologist and advocate on behalf of residents. It was found that there had been "inconsistencies in the implantation of the care plan". However, a comprehensive safeguarding plan was now in place for all residents. All of the residents spoken to by the inspector said that they "felt safe" in the centre.

In addition, the service had notified HIQA of two allegations of staff misconduct in 2016. Rehab Care services had undertaken investigation of these incidents. The issues raised had been investigated in accordance with policy on prevention of abuse of residents. Records were available to show that all staff had been trained in the safeguarding of vulnerable adults. The person in charge also confirmed that all staff had received this training.

There was a policy on supporting residents to manage their behaviour. Training records indicated that all staff had received training on dealing with positive approaches to behaviours that challenge. In the sample of healthcare files seen by the inspector one resident had a care plan entitled "behaviour management guidelines". These guidelines had been updated with the input from the Rehab Care service behaviour therapist. The guidelines were comprehensive and gave clear directions to staff on how best to prevent or appropriately respond to behaviour that challenges. Records seen by inspectors indicated that the implementation of these support plans was being reviewed on a regular basis.

The service provider was obliged to notify HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). HIQA was notified in September 2016 that a monitor used in bedroom for one resident. As part of the annual review of quality and care being provided in the service, the Regional Manager had identified this restriction and one other of a "hold" when chiropody was being provided to a resident.

Each of these restrictions had been approved by a restrictive practice committee comprising the service manager, the regional manager and the behaviour therapist in accordance with the RehabCare service policy. The regional manager confirmed there was not an overall service committee in RehabCare to review restrictions at an organizational level.

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

The inspector reviewed a sample of resident healthcare files and found evidence of regular reviews by the resident's general practitioner (GP). The GP requested review of residents' healthcare needs by consultant specialists as required.

There was evidence of good access to specialist care in psychiatry, both with residents attending as out-patients and via the community psychiatric liaison nurse who supported residents on site.

There was evidence that residents were referred for support as required by to allied health professionals including physiotherapy.

There was a policy and guidelines for the monitoring and documentation of residents' nutritional intake. The inspector noted that residents were referred for dietetic review as required and residents had nutrition care plans as required.

There was a weekly menu plan discussed at the residents' meeting. All meals were prepared by staff in the kitchen on site. A copy of the menu in picture format was available on the notice board. Staff were knowledgeable about residents likes and dislikes.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Each resident was protected by the centre's policies and procedures for medicines management. However, during the inspection some administration errors were noted.

Medicines for residents were supplied by the local community pharmacy. There was a comprehensive medication policy that detailed the procedures for safe ordering, prescribing, storage, administration and disposal of medicines. Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines delivered from the pharmacy corresponded with the medication prescription records.

There were no nurses employed in the centre and records indicated that all staff had received training on the safe administration of medicines. Staff demonstrated an understanding of medicines management and adherence to guidelines and regulatory requirements. Residents' medicines was stored and secured in a locked cabinet and there was a robust key holding procedure. Staff confirmed that medicines requiring additional controls were not in use at the time of inspection.

Compliance aids were used by staff to administer medicines to residents. The compliance aids were clearly labelled to allow staff to identify individual medicines. In addition, each medicines administration record had a picture and description of each tablet the resident was taking.

A sample of medicines prescription and administration records was seen by the inspector. During the inspection a number of administration errors were noted on one resident's administration record.

The inspector reviewed a sample of medication incident forms and saw that 38 medication errors were identified, reported on an incident form since January 2016. The person in charge had reviewed all incidents and preventative measures had been put in place. Training in medicines management had been scheduled for all staff in 2017.

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):
No actions were required from the previous inspection.

Findings:
The centre was managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

The person in charge was the service manager and was suitably qualified and experienced to discharge this role. She had a Masters degree in social care management and was the service manager of this centre since it opened in June 2015. The person in charge was supported by a team leader who had also worked in the centre since June 2015. The person in charge reported to the regional manager for Rehab services.

Rehab service had ensured that an unannounced visit to the designated centre in relation to the quality and safety of care had been completed in November 2016. This review included interviews with residents, families and staff members. There was a prepared written report available in relation to the issues that had been reviewed including: notification of adverse incidents, resident rights and safeguarding of residents safety.

An annual review of the quality and safety of care of the service had been completed in December 2016. The review looked at a number of issues including:
- quality and safety
- safe services
- effective services
- healthcare
- leadership
- resources
- workforce
- use of information

As part of the annual review Rehab Care service had engaged in consultation with the families of residents on the quality of care provided by the centre. Issues surveyed included quality of life, staffing, consultation, choice, communication with staff and the complaints process. The results from these surveys stated that there had been a strong improvement in the quality of life for residents since moving to this community based residence.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that, based on the assessed needs of residents, there were sufficient staff with the right skills, qualifications and experience to meet those needs. Staffing levels reflected the statement of purpose and size and layout of the buildings.

The inspector met with staff and observed their interactions with the residents. Staff had good knowledge of each resident's individual needs and were seen to support residents in a respectful and dignified manner.

An actual and planned staff rota was maintained. A copy of this rota was available in a picture format so that residents were aware of which staff were on duty. There were a minimum of two staff on duty at all times including an “awake” staff and a sleepover staff at night.

While reviewing the incident reporting system the inspector noted one incident where due to staff illness there had only been one staff on duty overnight. This incident had been reviewed by the person in charge and discussed with all staff at team meetings. Protocols had been put in place to prevent a similar event occurring in the future including the timely notification of any proposed absence. There was also an emergency on-call system in place in the event of a similar event in the future. Staff spoken with were knowledgeable about the emergency arrangements in place if, for example, a resident needed to attend hospital during out of hours or at the weekend.

The person in charge confirmed that there had been turnover of staff with three vacancies on the roster. The regional manager confirmed that these vacancies had been filled and that there was a full complement of staff available.

Staff training records demonstrated a commitment to the maintenance and development of staff knowledge and competencies. All staff had a minimum qualification to Further Education and Training Awards Council (FETAC) Level 5. Records indicated that all mandatory training had been be provided to staff including fire safety, crisis prevention and safeguarding.

Judgment:
Compliant

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:

Kieran Murphy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority **Regulation Directorate** **Action Plan**

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0005231
Date of Inspection:	05 and 06 January 2017
Date of response:	30 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge outlined that following a healthcare appointment staff recorded the outcome of the appointment. However, the resident's personal plan was not always accurately updated following these appointments.

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 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:
• Staff were advised at team meeting on 20th January that when a resident attends a healthcare appointment, the notes will be transcribed by the healthcare professional at the appointment.

• This new information in relation to the resident needs will then be reflected in the residents support plan.

• Staff training on the development and monitoring of Support Plans has been scheduled for 23rd February. The aim of this training is to enhance staff the skills when updating and reviewing support plans so that they give a comprehensive account of the resident's current health status and needs.

Proposed Timescale: 23/02/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The process for person-centred planning and goal setting required improvement. In particular it was not identified what supports the person needed to achieve the things they liked to do and also there was not a timeframe identified for the person to achieve their goals.

2. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
• PCP meetings for each resident have been scheduled for 2017 and relevant people in the individual's lives have been invited to attend, these have commenced and will be completed by 11th February. Action plans and goals will be reviewed following each meeting by the keyworker and team leader and timeframes and supports put in place for the plans.

• Staff are scheduled to attend training on March 15th in the area of PCPs and developing action plans for any identified goals. The training is centred on RehabCare Service User Pathway which goes through all steps undertaken for a successful supporting service users to achieve their goals.

Proposed Timescale: 15/03/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal planning process was not the subject of a multidisciplinary annual review as required by the regulations. Therefore the process did not address the supports that may be required from other healthcare professionals that would best meet the resident's needs in using combined strategies.

3. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
• Multidisciplinary meetings for each resident are currently being planned for 2017. Dates for these meetings will be finalised by Feb 6th 2017.

• The residents have a number of professionals that are involved in their healthcare and these will be invited to attend the MDT meetings. The meetings will invite care staff/keyworker, team leader, manager, family member, GP, psychiatrist, psychologist, dietitian (if replacement available for current vacancy), OT, speech and language therapist and any other professional or individual who is deemed a support for that individual.

• These reviews will coincide with PCP meetings for each resident so that healthcare needs and any necessary supports can be a part of each residents person centred plan.

Proposed Timescale: 27/02/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents had been admitted to an acute general hospital during the year. However, there was no information on file in relation to these hospital admissions. In particular an assessment of residents' health needs had not been completed and their care plan had not been updated to reflect the instructions of the discharging hospital team.

4. Action Required:
Under Regulation 25 (2) you are required to: On the return of a resident from another designated centre, hospital or other place, take all reasonable actions to obtain all relevant information about the resident from the other designated centre, hospital or other place.

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

• Instructions are now in place for care staff that support the residents to hospital appointments and admissions. These instructions form part of each residents support plan and are also in each resident's medical file. These instructions detail that following a hospital appointment or admission, any information that follows should not only be sent to GP but needs to be returned to the service and documented accurately with the residents support plan so that instructions from the discharging team in the hospital can be followed through accurately.

• For each diagnosis and condition pertaining to each resident a specific condition plan will be developed that will detail how that person is supported and what that particular condition/diagnosis means for that person's life. This is in line with revised organisational policy.

• An assessment of each residents health needs was undertaken in September 2016 but it will be undertaken again in February 2017 to reflect new information and also to include the feedback from the annual reviews. This will give a more accurate and comprehensive needs assessment for each resident.

Proposed Timescale: 27/02/2017

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:
Improvement was required in relation to the management and ongoing review of risk on the centre risk register.

5. 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:
Service Manager has updated the local risk register to include all risks that currently pertain to the service and its residents. This includes; Safeguarding vulnerable adults, Administration of medication, Absence of community dietitian for six months, Health and Safety and Personal care.

This register will be continuously reviewed by the service manager so that all new risks can be identified, recorded and managed. It will also serve to monitor current risks and their ratings and current control measures in place.

Proposed Timescale: 09/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Hand drying facilities were not available in the staff office and staff were observed washing their hands in the office and drying them elsewhere.

6. 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:
Hand towel dispenser to be installed next to office hand wash basin.

Service manager has contacted HSE Infection Prevention and Control nurse who will carry out an Infection Prevention and Control review within the service which will give good indication as to what can be improved on in this area. The review will include Hand Hygiene, General Environment, Management of Medical and Care Equipment and healthcare risk waste, Sharps Handling & Disposal, Management of Laundry, Safe management of body fluids and use of PPE. The review will lead to findings and recommendations that will enhance the quality of infection prevention and control in the service. The service manager will ensure adoption of any recommendations made are in line with organisational policy.

Proposed Timescale: 06/02/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of administration errors were noted on one resident's administration record.

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

Please state the actions you have taken or are planning to take:
All staff in the service attended Refresher training in the Safe Administration of Medication on the 24th January. Each staff member will be reassessed following the training to assess their competency in administrating medication.

Any errors following retraining will be addressed with the individual staff member.

Service manager to make contact with local pharmacy who will provide an information session for to the staff team medication administered within the service, types of medication and their specific requirements and uses.
Proposed Timescale: 06/02/2017