

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Camphill Community Dingle
Centre ID:	OSV-0003609
Centre county:	Kerry
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Lead inspector:	Carol Maricle
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 17 January 2018 12:00 To: 17 January 2018 18:30

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This was an unannounced inspection carried out to monitor compliance with the regulations and standards. This was the third inspection of this designated centre for adults with disabilities.

How we gather our evidence

As part of the inspection, inspectors met and interacted with seven residents, some of whom could engage verbally with the inspectors and they reported that they were satisfied with life in the centre and the care given to them by staff. Inspectors reviewed documentation such as personal plans, risk assessments and medicines management. The inspectors met with a person involved in the management of the centre, the house-coordinator, social care staff and volunteers. The person in charge was not on site on the day of the inspection.

Description of the service

The provider must produce a document called the statement of purpose that explains the service they provide. Inspectors found that the service was being provided as it was described in that document. The centre comprised one detached house located

in a rural location close to a large town. The service was available to adult male and females who have been diagnosed with an intellectual disability. At the time of the inspection there were seven residents living at the centre and one vacancy. A service user was preparing for admission to the centre while a number of current residents were preparing to move from this centre to a separate dwelling later in the coming year.

Overall judgment of our findings

Inspectors found a good level of compliance in areas such as personal planning, suitability of the premises and staffing. These findings were coupled with meaningful progress against the action plan from the previous inspection. The house was modern, homely, warm and comfortable. Photographs on display throughout the houses clearly showed how the residents integrated with the local community. However, there was poor governance of the HIQA notification process resulting in late submission of notifiable events.

There were some actions that arose as a result of this inspection; for example:

- risk assessments (outcome 7)
- restrictive practices (outcome 8)
- notifications (outcome 9)
- assessment of capacity to self-administer medication (outcome 12)
- an aspect of governance and management (outcome 14)
- aspects of record keeping (outcome 18).

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.

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):

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

Findings:

The provider had systems in place to ensure that personal planning arrangements were established. The needs of residents were assessed. Personal planning arrangements were subject to review in conjunction with the resident. There were appropriate systems in place for admissions and discharges. Actions arising from the previous inspection had been satisfactorily implemented.

Each resident had personal planning arrangements in place and this set out a range of information about each individual, such as, important information for staff to know, their likes and dislikes, their abilities in the area of communication, hospital passports and individualised risk assessments. Each resident had identified written goals for the year. All residents had assigned key workers who took the lead on supporting residents to achieve these identified goals. An inspector met with a resident who discussed their goals for the coming year that they expressed excitement about. Where possible, personal plans were devised and signed by the resident with support from their key worker and other relevant staff.

There was regular review of personal planning arrangements by the house co-ordinator. This ensured that plans were up-to-date and contained the required documents.

There were systems in place regarding residents' assessments of need. Assessments were conducted by qualified social care workers in conjunction with the house co-ordinator. This assessment addressed a range of strengths and needs in areas such as healthcare, the well-being of the resident and their daily life, education and training.

The manner in which each personal plan was reviewed in a multidisciplinary manner was not clear at first as there was no evidence of a formal multidisciplinary meeting having taken place. However, the house co-ordinator showed the inspector information for a sample of residents that demonstrated showed how each resident regularly liaised with their healthcare professionals and that relevant information from these meetings was incorporated into the personal planning process.

At the time of the inspection the inspectors were introduced to a service user who was due to move into the centre on a full-time basis. The house co-ordinator showed evidence to the inspector of the planning that had taken place to date which was appropriate to the needs of the individual. Some aspects of the actual transition planning document required updating and the house-coordinator committed to the completion of same following the inspection. The inspectors were informed that two current residents were preparing to move from the centre to a separate dwelling. There were written plans shown to the inspector demonstrating the planning involved in this transition.

Judgment:

Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

Since the previous inspections residents had moved into a new premises which addressed previous failings in this area.

During the previous inspection residents were living in two separate units. Following failings relating to the overall maintenance of these units, decoration and fire safety issues, the provider had moved all residents into a new purpose built premises. At the time of this inspection the designated centre was comprised solely of this new premises which housed both residents and volunteers in line with the provider's model of care.

The designated centre was presented in a clean manner throughout and observed to be in a good state of repair. Inspectors observed the premises to be suitable to meet residents' needs. The premises was appropriately decorated to give a homely feel while residents had ample space to relax with spacious bedrooms also provided.

Inspectors were satisfied that all of the requirements of the regulations were provided for at the time of this inspection. For example suitable storage facilities, communal space, ventilation and a sufficient number of toilet facilities were all in place. Accessibility was appropriately provided for in the designated centre.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The transition of all residents to a new premises had made a significant improvement regarding fire safety arrangements in the centre.

It was found during the previous inspection that adequate fire safety measures were not in place in two units where residents lived in. However since that inspection all residents had left these units and transitioned into a new purpose built premises. A fire alarm system, emergency lighting, fire doors and fire fighting equipment including fire extinguishers were present in the designated centre. Emergency lighting was seen to be operational on the day of inspection while fire exits were also observed to be unobstructed. Inspectors saw records of certificates of maintenance carried out by external bodies for the fire alarm system and the fire extinguishers.

Internal staff fire safety checks were being carried out and documented. Fire drills were being carried out at regular intervals and recorded as such while fire safety signage was in place. Training records reviewed also indicated that all staff members had received up-to-date fire safety training. Other training was also provided in relevant areas such as manual handling and infection control.

The previous inspection found that improvement was required in relation to the assessment of risk. During this inspection a risk register was in place containing risk assessments which affected the centre as a whole and had been recently reviewed. Risk assessments relating to individual residents were contained within their personal plans. While these had also been updated recently it was noted that some did not adequately describe the nature of the risk or contained some information that was out of date.

Appropriate policies relating to health and safety and risk management were in place including a risk management framework which had been last reviewed in May 2017 and

an emergency plan for the centre. A process for recording accidents and incidents occurring in the centre was in place. A system for learning from such adverse events was in place while minutes of staff team meetings were reviewed which indicated that such incidents were discussed.

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):

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

Findings:

The organisation had systems in place to protect residents and keep them safe. At the previous inspection, an action had been given in relation to training. This action had since been implemented.

There was an organisational policy in place regarding the safeguarding of residents. Inspectors reviewed training records and noted that staff had been provided with training in safeguarding and supporting those who exhibit behaviours that require a response. During interview, staff with whom the inspectors met with confirmed their awareness of safeguarding issues and pathways of reporting should a concern arise in this area.

Each resident, whose file the inspectors viewed, had an assessment of their ability to self-care and arising from this, an intimate care plan was created where necessary.

Where necessary, residents were facilitated to access support from appropriate services to address any behaviours of concern, for example psychology and psychiatry. Residents could also be referred to a regional service specialising in behavioural support. Some residents had behavioural support plans in place that set out the most appropriate way for staff to respond to behaviours. On the day of the inspection, residents were observed interacting with staff who supported them in a positive manner that was not rushed. There was plenty of chat and laughter between residents and staff.

The inspectors reviewed the use of restrictive practices at this centre. Overall, there was

low use of restrictive practices throughout the centre. Residents were only restricted in their environment to access to offices containing medication. There was, however, an environmental restrictive practice used for which there was insufficient documentation accounting for the rationale of same. The use of this practice for safety reasons pertaining to a healthcare issue was not documented in such a way that it was demonstrated that it met the requirements of the Regulations.

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):

No actions were required from the previous inspection.

Findings:

There was poor governance demonstrated of the HIQA notification process.

Prior to and during this inspection, it was identified that notifiable events had not been submitted to HIQA in line with the Regulations. It was identified by HIQA that quarterly returns had not been received for the first two quarters of the year of the inspection and some quarters of the previous year. These were submitted by the person in charge prior to this inspection.

During the inspection the inspector informed a person involved in the management of the centre that the quarterly submission for quarter three of 2017 was now also outside of the timeframes for submission to HIQA. This was resolved immediately following the inspection, however a restrictive practice had not been included on this quarterly notification. This was further resolved. A follow up report to an allegation of abuse had not been forwarded to HIQA within the required timelines, however, this was also resolved following the inspection.

Although all of the above issues were resolved either prior to, during or immediately following the inspection the quantity of the above showed how there was poor governance of the process by those involved in the management of the centre and those representing the provider. The arrangements to address this finding were being finalised at the time of completion of this report. The person in charge informed the inspector that a deputy role was being advertised by the organisation and this post-holder would assist in the day-to-day management of the centre to include the submission of notifications.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

There were systems in place to ensure that the healthcare needs of residents were identified, assessed and met. At the previous inspection an action had been created around end-of-life plans. This action has since been implemented.

Residents had access to general practitioners (GPs). They also had access to a multidisciplinary team based in the community and this included disciplines such as general practitioner, dentistry, psychology, psychiatry and behavioural support. The house-coordinator confirmed to the inspector that the residents frequently attended their GP and records viewed confirmed these arrangements.

The inspectors found that needs identified in the residents' healthcare assessments were cross-referenced in their personal planning arrangements and further addressed in their goals. On occasion, residents did not always choose to follow particular health guidelines and not all residents had a risk assessment of this issue undertaken. This has been addressed in outcome 7.

There were systems in place to address end-of-life care plans where applicable.

An inspector found recommendations on file from a speech and language therapist recommending a referral to occupational therapy which had not at the time of the inspection been actioned. The house-coordinator acted on this immediately and showed evidence of follow through by the completion of the inspection. An inspector found in one file discrepancies in information pertaining to a food intolerance. The house co-ordinator clarified the situation and committed to the immediately reviewing this discrepancy.

The inspectors observed lunch being provided to the residents and staff. There was a variety of food on offer that afforded choice to the residents. Some of the food was directly sourced from the gardens of the grounds of the centre. Residents participated in the preparation of the setting of the table. There was a good atmosphere at lunchtime and it was an occasion for residents and staff to sit together and share a meal. It was clear to the inspectors that meal times were a joyous occasion at the centre with lots of

chat and laughter.

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:

Secure facilities for the storage of medicines and appropriate procedures were in place to ensure that residents were provided for in this area.

Medicines were administered by staff who had received training in this area. The process for recording accidents and incidents occurring in the centre also applied for errors relating to medicines. Inspectors saw evidence that this process had been followed with appropriate action taken to respond to medicines errors of a similar nature. Self-administration of medicines had been explored with residents by staff members, however, this was not in place for all residents.

Inspectors reviewed the storage facilities provided for medication and observed them to be neatly organised. Appropriate separated storage for medicines that were to be returned was also provided for. Stocks of medicines taken as required (PRN) were maintained in the centre. Arrangements were also in place for the monitoring of stock levels with records of stock level checks seen by inspectors during the course of the inspection.

A sample of prescription and administration records were reviewed by inspectors. It was found that the required information such as the medicines' names, the medicines' dose and the residents' date of birth were contained in these records. Records indicated that medicines were administered in accordance with the timeframe on the prescription.

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):

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

Findings:

There were effective governance systems in place on a day-to-day basis in relation to the quality and safety of the service. At the previous inspection, there had been a number of non compliances found in this area and an action plan response had been accepted by HIQA. At this inspection, these actions were seen to have been completed. However, as per the findings referenced in outcome nine, there was poor governance of the HIQA notification process which was a reflection of the capacity and capability of the service.

There was a clearly defined management structure in the centre. The staff team consisted of social care workers who reported to the house-coordinator, who in turn, reported to the person in charge. Volunteers reported to a person involved in the day-to-day management of the centre, who in turn reported to the person in charge. The person in charge was supported by a number of persons involved in the day-to-day management of the centre, two of whom the inspectors met with at this inspection. Residents confirmed their awareness of who was in charge.

There were systems in place for the annual review of the centre and the review contained a number of actions; the person in charge confirmed their completion. However, it was not explicit in the review whether it included consultation with residents and their representatives.

There had been two six monthly inspections conducted by the registered provider representative in the previous 12 months. However, the most recent six monthly inspection of the centre failed to identify the failures regarding the notifications process.

Judgment:

Substantially 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):

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

Findings:

Improvements had been made in the staff skill mix in the centre while there were suitable numbers of staff and volunteers available to meet the needs of residents.

The designated centre's workforce consisted of a combination of short term volunteers, long term volunteers and paid members of staff in line with the provider's model of care. The previous inspection had found that the staff skill mix required review to ensure appropriate assistance, intervention, care and support for residents. Since then the number of paid and suitably qualified staff members had increased which was reflected in the improved compliance found during this inspection.

Throughout the inspection members of the workforce and residents were observed engaging in a caring and warm manner which was reflected by a positive atmosphere throughout the centre. Having reviewed planned and actual rosters available in the centre, inspectors were satisfied that there were appropriate levels of staff and volunteers to meet the needs of residents. Rosters also indicated that a continuity of staff and volunteers was provided for.

Training records reviewed indicated that all staff, including the volunteers, had undergone relevant training in a numbers of areas including fire safety, medicines management, de-escalation and intervention and safeguarding. A sample of staff files were also reviewed and were noted to contain all of the required information such as evidence of Garda Vetting, two written references and proof of identity. Files relating to volunteers working in the centre were also reviewed and were found to include evidence of Garda Vetting.

Staff team meetings were taking place at regular intervals. Inspectors reviewed a sample of minutes from these meetings where issues such as resident activity, accidents and incidents, policies and training were discussed. Arrangements were in place for staff to receive supervision and formal supervision meetings with staff took place throughout the year. Records of such meetings were maintained which were reviewed by inspectors.

Judgment:

Compliant

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):

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

Findings:

This outcome was not inspected in full. The action from the previous inspection had been addressed. It was noted on this inspection that there were some gaps pertaining to records regarding personal planning.

Having reviewed a sample of personal planning arrangements, the inspectors observed that was inadequate and evidenced written oversight by the management team of key documents, such as body maps and other documents relating to personal planning.

Communication passports required better dating and signing to show authorship.

An inspector reviewed a sample of minutes from welfare meeting attended by staff concerning the overall welfare of each resident. It was not documented that the actions discussed at these meetings were followed up at the next meetings nor was it minuted the nominated persons responsible for each action.

Judgment:

Substantially 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:

Carol Maricle
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 report¹

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003609
Date of Inspection:	17 January 2018
Date of response:	08 March 2018

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 07: Health and Safety and Risk Management

Theme: Effective Services

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

Some risk assessments relating to individual residents did not adequately describe the nature of the risk and contained some information that was out of date.

1. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated

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

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:

- A review of risk assessments for each resident will be completed. Information will be updated by cross reference to personal file documentation such as the up to date needs assessment, behaviour support plan, safeguarding and personal plan of each resident to ensure each individual's risk assessment are fully up to date and describe the nature of the risk and the mitigation actions taken to reduce risk.
- Personal risk assessments will be updated as needs/risk changes.
- Resident quarterly reviews will include a review of personal risk assessments.
- Quarterly reviews of all residents will be counter signed off by the Person in Charge

Proposed Timescale: 27/04/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The use of a restrictive practice for healthcare reasons was not documented in such a way that it demonstrated compliance with the Regulations.

2. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

A review of restrictive practice by the National Safeguarding Coordinator and Person in Charge will be completed to ensure clear rationale of any restrictive practice is in place and documented.

Proposed Timescale: 30/04/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Notifications were not submitted to HIQA within the time periods as set out by the Regulations.

3. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief

Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

- Person in Charge will ensure all notifications are submitted in a timely matter and all notifications are up to date.
- An additional Office Administrator has been recruited to support the administration process in the Community.
- Compliance will be monitored by the PiC's line manager.

Proposed Timescale: 19/02/2018

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:

Not all residents had an assessment of capacity developed in relation to their ability to self-medicate.

4. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

-Each resident in the designated centre will have an assessment of capacity completed in relation to their ability to self-medicate and will be reflected in their personal plan.

Proposed Timescale: 06/04/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The annual review was not explicit in referencing consultation with residents and their representatives as part of the review process.

5. Action Required:

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for

consultation with residents and their representatives.

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

-The Provider has in place two survey templates to ascertain the views of residents and their representatives. The Person in Charge will ensure the surveys are completed by residents and their representatives. The survey is currently set up on Survey and residents will be offered independent support to complete the survey.

-The Provider will ensure that the learning from the surveys is included in the quality improvement plan for the Community.

-The Provider will ensure in future the annual review of the quality and safety of care and support

Proposed Timescale: 15/05/2018

Theme: Leadership, Governance and Management

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

The most recent six monthly inspection of the centre failed to identify the failures regarding the HIQA notifications process.

6. 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 will ensure the six month unannounced inspection report contains an analysis of compliance in respect to the notifications.

To facilitate this the Person in Charge will ensure the incident register folders which the Regional Manager has oversight of are maintained and up to date. These registers facilitate oversight and data collection in respect of the unannounced inspection.

The Person in Charge will inform the Regional Manager of notifiable incidents and obtain sign off of notifications prior to submission to HIQA.

The Person in Charge will copy the Provider into the quarterly returns to HIQA.

The Person in Charge will submit a weekly checklist to the Regional Manager which monitors incidents.

Proposed Timescale: 12/03/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

Some documents pertaining to residents required better dating and signing to show authorship. Decisions recorded in meetings affecting the welfare of residents required better recording of the persons responsible for implementation of such decisions. There was inadequate demonstrated written oversight by the management team of key documents, such as body maps and other documents relating to personal planning.

7. Action Required:

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

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

-A schedule of review to be completed to ensure oversight by management of the resident's personal plan.

Due for completion 30/3/2018

-All personal plans and quarterly reviews will be counter signed off by the Person in Charge.

Due for completion 27/4/2018

-All personal plans to be updated to reflect appropriate dates and authorship from the appropriate discipline and MDT.

Due for completion 27/4/2018

-Welfare minutes and action to show clear rationale, implementation dates and person responsible for any action required in relation to the welfare needs of the residents.

6/3/2018

Proposed Timescale: 27/04/2018