Health Information and Quality Authority Regulation Directorate

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

Centre name:	Adults Services Lucan Designated Centre 11
Centre ID:	OSV-0003908
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stewarts Care Limited
Lead inspector:	Thomas Hogan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
17 January 2018 09:30	17 January 2018 18:35
18 January 2018 08:00	18 January 2018 17:10

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

Outcome 01: Residents Rights, Dignity and Consultation
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 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 an announced inspection to assess the designated centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was conducted as part of the provider's assessment of application to renew the registration of this designated centre. It was the Health Information and Quality Authority's (HIQA) fourth inspection of this designated centre and it was completed over two days by one inspector.

Description of the service:

The service provider had produced a statement of purpose which outlined the service provided within this designated centre. The centre comprised of five separate units based in community settings in West County Dublin. The centre provided residential services and supports to 19 persons and at the time of inspection there was one vacancy.

How we gathered our evidence:

The inspectors met with 12 of the residents availing of the services of the centre and spoke in detail with six residents. The inspectors also spoke with eight staff members, the person in charge, the programme manager, and the director of care. Various sources of documentation, which included the statement of purpose, residents' files, centre self-monitoring records, policies and procedures, risk assessments etc., were reviewed as part of this inspection. Additionally, in assessing the quality of care and support provided to residents, the inspectors spent time observing staff engagement and interactions with residents.

One questionnaire completed by a resident, relatives or friends was received by the inspector and this was reviewed. A full walkthrough of the centre was completed by inspectors in the company of the person in charge.

Overall judgment of our findings:
Ten outcomes were inspected against as part of this inspection and the inspectors observed a high level of non-compliance with the Regulations. Three of the ten outcomes inspected against were found to be in major non-compliance with the Regulations, with four outcomes found to be in moderate non-compliance, and three outcomes found to be substantially compliant. Major concerns found during this inspection included the areas of incident management, safeguarding residents from abuse, the governance and management of the designated centre, and the management of medication.

These findings, along with further details, can be found in the body of the report and accompanying action plan.

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

Findings:
Overall, the inspector found that some improvements had been made in the area of residents' rights, dignity and consultation since the time of the last inspection. Despite this, one action required from the previous inspection was found not to have been satisfactorily addressed.

A review of complaints received in the designated centre was completed by the inspector and it was found that one complaint was made in the period since the last inspection. There were a total of three complaints made in 2017. The inspector found that systems in place for maintaining a log of all complaints and actions taken to address concerns was not satisfactory. However, assurances were provided by the representative of the service provider when outlining organisational processes underway which included the establishment of a sub-committee of the board to oversee complaints management.

The inspector found that arrangements for residents to freely access their personal financial funds had improved somewhat in the time since the last inspection, however, staff members and the person in charge confirmed that barriers remained in place. Residents could only access money and savings by request through a centralised account service managed by the provider. A new 'float system' meant that residents had an increased baseline amount of money available locally, however, had to wait between three days and one week to gain access to finances greater than this 'float' amount.

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

Findings:
The inspector reviewed the action from the previous inspection and found that satisfactory responses had not taken place by the provider to address the matter of fees being charged to residents for transport services being outlined in written agreements.

A review of 19 resident files found that 16 full written agreements were in place and available with an additional three files containing only one page of the agreement. All written agreements dated from 2014 or 2015 and none outlined the fees to be charged to residents for transport services. The representative of the service provider outlined to the inspector that at the time of inspection that no residents were incurring fees for any transport services and that this matter was under review with an organisational policy committee. A new policy on this matter was due for ratification in the coming months.

The inspector identified that written agreements in place for seven residents did not at the time of inspection reflect the 'long stay service charge' being incurred by residents. One resident was found to be incurring a charge of €18.57 per day while the remaining six residents were found to be incurring a range of charges below the fee outlined in their written agreements.

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

Findings:
The inspector found that while residents were supported with opportunities to engage in meaningful activities, overall, these opportunities were not guided through individualised assessed needs or the personal plans of residents.

Assessments of need were completed for all residents availing of the services of the designated centre, however, the inspector found that these were not comprehensive in nature and while focusing on health related matters and did not adequately assess the personal and social care needs of residents. The completed assessments were found to have four sections relating to self-care, risk, independence, and health. Overall scores calculated did not indicate levels of support required, or how scores impacted on planning processes. In addition, the inspector was unable to identify who participated in the assessment process as grades of staff completing the assessments were not listed.

The inspector reviewed personal plans in place for eight residents and found that overall these did not reflect the findings of the completed assessments of need or outline arrangements for meeting the assessed needs of residents. A 'Path Plan' system was in place in the designated centre and six of the eight files reviewed by the inspector were found to have such plans in place. Upon review of these plans, the inspector found that no entry was made in one case since March 2016; in another case since February 2017; and in a third case since May 2017. In the case of one resident with no 'Path Plan' in place, a review of the file indicated that only one goal was in place which was "…to continue to fulfil…aspirations as a valued member of society". There was no further detail provided on how this goal was to be achieved for this resident or what actions had been taken since May 2017 when this goal was created.

A review of 'meaningful activity' records found that in the case of one resident 21 activities were logged for a 17 day period. The inspector found, however, that on one day the only activity logged was "relaxed" while another day had only one log which was "clean up". For a second resident 64 activities were logged for a 67 day period. The inspector found that in this case 'meaningful activities' included participating in house hold tasks, relaxing, resting, laundry and clean up (which accounted for 13 of the 64 entries), attending medical appointments, and participating in a fire drill.

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

Findings:
The inspector found that the design and layout of the designated centre was suitable for it stated purpose.

While it was found that all actions relating to safe and suitable premises form the previous inspection were satisfactorily implemented and addressed, the inspector found that areas in two units of the designated centre required painting and decoration. In one unit the areas identified included a stairwell/hallway and an upstairs bedroom, while in a second unit painting and decorating was required in one bedroom, a hallway and a sitting room.

The inspector found that there was adequate private and communal accommodation for residents in the designated centre, and suitable arrangements were in place for the storage of personal belongings of residents. There were baths, showers and toilets of a sufficient number to meet to the needs of residents.

There were suitable arrangements in place for the disposal of general domestic waste.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
The inspector found that while improvements had been made in the area of health and safety and risk management in the period since the last inspection, and all actions arising from that inspection had been satisfactorily addressed, some concerns remained

relating to fire safety and incident management.

Six emergency fire exit routes across four of the individual units of the designated centre were found not to have emergency lighting in place at the time of inspection. One of these routes, which was listed as being a "primary escape route" on the local emergency evacuation plan, was through a garage door. The inspector found, however, that upon an attempt to open this door that it was not possible to do so and could only be opened from outside the building. The person in charge and staff members were not previously aware of this concern.

A review of incidents, accidents and near misses which had occurred in the designated centre in a three month period was completed by the inspector. A total of 38 incidents had occurred in this period. 12 of these incidents related to behaviours which challenge; 14 related to potential experience of abuse of residents; one related to an unexplained injury sustained by a resident; three related to medication errors; three related to falls/slips/trips of residents; and five related to other types of incidents, accidents or near misses. The inspector found that there were five incidents where satisfactory measures were not taken in response to risks identified. Some examples of incidents included for which there was an absence of satisfactory response from the registered provider included alleged peer to peer physical and verbal abuse, unexplained injury sustained by a resident, and the unexplained absence of a resident from the designated centre.

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

Findings:
The inspector found that appropriate measures were not in place in the designated centre to protect residents from being harmed or experiencing abuse. Appropriate action was not taken in response to allegations or suspicions of abuse in the designated centre.

Of a sample of 37 incident reports reviewed by the inspector, 14 of these related to the potential experience of abuse by residents and one additional incident related to unexplained injury sustained by a resident. Of these 15 incidents, four were found not to have been managed in accordance with the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014) document. These four incidents involved two alleged peer to peer abusive occurrences, an alleged peer to peer physical interaction, and unexplained injury sustained by a resident. These incidents of safeguarding concerns were found not to have been appropriately identified, reported or investigated.

A review of staff training records found that 69.6 per cent of the staff team employed in the designated centre had completed mandatory training in Safeguarding Vulnerable Persons. The inspector spoke in detail with five members of staff regarding the identification of abuse, the types of abuse, what to do if abuse was suspected or witnessed, and the identity of the designated safeguarding officer. Overall, the inspector found that staff awareness of these areas had improved in the period since the last inspection.

The inspector read two behavioural support guidelines in place in the designated centre to support residents manage behaviours of concern. It was found that the emotional needs of residents were supported and evidence was available that the behavioural support guidelines were implemented in practice. Guidelines outlined proactive and reactive strategies to support residents with emotional needs.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Overall, the inspector found that residents were satisfactorily supported to maintain and achieve good health. Improvements were required in the area of health care planning to ensure appropriate guidance in place for supporting residents achieve and maintain best possible health.

The inspector reviewed completed 'ok checklists' and 'annual medical reviews' and found that these had been completed for all residents in the previous 12 months. A review of

15 resident files found that 11 identified medical conditions did not have corresponding health care support plans in place. Some examples of conditions which did not have a health care support plan in place included asthma, hypertension, anxiety, compulsive disorder, depression, bowel disorder, and schizoaffective disorder. Having reviewed the health care support plans which were in place, the inspector found that plans did not guide the practice of staff and were not reviewed for their effectiveness on at least an annual basis. Health care support plans did contain information on the health condition, however, in the case of an epilepsy health care support plan did not for example include direction for staff on what to do in the event of seizure occurring. There was no evidence available of multidisciplinary inputs for reviewing health care support plans.

The inspector observed meals being served in one unit of the designated centre and found that it was a positive and social event. There were a range of choices available to residents and the food being service appeared nutritious, appetising and was available in sufficient quantities.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
The inspector found that residents were potentially put at risk by some medication management practices in the designated centre. Actions which arose from the previous inspection relating to medication management were found not to have been satisfactorily addressed.

In one unit of the designated centre, the inspector observed a key box left unopened with keys inside to a medication cabinet. This was brought to the attention of staff members who attended to the matter and ensured that the keys were appropriately stored.

A review of one medication cabinet in the designated centre found that one PRN medication (medication only taken as the need arises) was outside of the stated expiry date. A second PRN medication was found to have no expiry date available.

A medication administration recording sheet review for one resident completed by the

inspector found that an anti-epilepsy medication was not administered as prescribed on one occasion, and a medication prescribed for a skin condition was found not to have been administered as prescribed on several occasions. The medication used to treat a skin condition was prescribed to be administered twice weekly, however, was administered on three occasions in a four day period in mid December 2017, only administered on one occasion in late December 2017, and was not administered in a 16 day period in early January 2018. No incident forms were found to have been completed to reflect these medication errors.

A staff member who was spoken with by the inspector in one area of the designated centre confirmed that they had responsibility for the administration of medication including emergency rescue medication for epilepsy. When asked about the criteria for administering this medication in an emergency situation, the staff member was aware of only one of the three criteria listed on the resident's protocol.

Evidence of completed monthly medication audits were made available to the inspector. These were found to examine areas including records, labeling, storage, administration and training, errors, and action plans. The inspector found, however, that concerns identified at the time of inspection had not been identified and/or acted on by the management team.

Judgment:
Non Compliant - Major

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:
The inspector found that the management arrangements in place in the designated centre at the time of inspection did not ensure that the service delivered was appropriate and effectively monitored, with appropriate action taken to address issues of concern.

At the time of inspection two managers were present in the designated centre and

planned on becoming the persons in charge of two individual designated centres when reconfiguration plans were put in place. This formed part of an overarching organisation wide plan included the designated centre being divided into two separated centres. No application for this development had been received by HIQA at this time of this inspection. The inspector found that while the plans outlined were in the initial phases of implementation, they had not had sufficient impact on addressing three of the four actions which arose from the last inspection relating to the governance and management of the designated centre.

The inspector met and spoke in detail with both managers which were present in the centre and found that they demonstrated sufficient knowledge of the legislation and statutory responsibilities. At the time of inspection, one of the managers spoken with was found to have significant responsibilities for the management of other designated centres, had a once weekly full day of commitment to creating rosters for all areas of the community service, and on-call commitments for community service areas within the wider organisation. The managers spoken with acknowledged that these responsibilities had an impact on the role of person in charge in the designated centre. Despite this, staff members spoken with by the inspector outlined that they found the managers to be available and supportive.

The inspector found that the management structure in the designated centre was not clearly defined at individual unit level and the person(s) responsible for the management of units was not clearly set out. The arrangements of staff members at unit level to manage individual units was not appropriate given their level of experience and scope of responsibilities.

An annual review for 2017 was found not to have been available at the time of inspection. A programme manager informed the inspector that this was not completed and was expected to be finalised by the end of February 2018. An annual review for 2016 was available, however, in the absence of a completion date it was not clear if this was prepared in the previous 12 months. Reports from five unannounced six monthly visits by persons on behalf of the representative of the registered provider were made available to the inspector. One report related to each individual unit of the designated centre. Four of these reports were completed in November 2017 and one report did not have a completion date included. The inspector found that no family members or representative of residents were consulted with in any of the five unannounced visits completed. Similarly, no visit included a review of incidents in that area or a summary of actions taken by the registered provider arising from analysis of notifications submitted to HIQA. There were action plans formed for all five unannounced visits with completion dates set for concurs identified, however, in all five cases the inspector found that actions remained outstanding with dates for completion having passed.

The inspector found that the actions identified during the six monthly unannounced visits to the designated centre did not overall reflect the findings of concern identified a the time of inspection. On the day of inspection, a number of issues relating to the identification of potential abusive incidents, their appropriate reporting and management in line with national policy were identified. In addition, concerns relating to the safety of residents as a result of medication management practices were also identified.

The arrangements for replacing managers and the person in charge for both planned and unplanned absences from the designated centre was found not to be satisfactory by the inspector. During a recent six week absence of the person in charge, the inspector found that no identified person was discharging the duties associated with this role and instead the on-call support was providing minimal support through rostering functions.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
The inspector found that while at the time of inspection there were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services, this was not reflective of the service provided on all occasions in the month prior to the inspection.

Through a review of staff duty rosters and discussions held with staff members and managers, the inspector found that three units of the designated centre regularly operated below their minimum staffing levels. In one area of the designated centre, the inspector found that there was a significant reliance on 'relief' and agency staff to maintain minimum staffing levels with only two long term staff deployed to the unit. In another area, a staff member who was on maternity leave was found not to have been replaced and as a result half of the staff roster was operating below the minimum stated staffing levels for this unit.

Significant gaps were found in staff training in all mandatory training categories. 26.1 per cent of staff were found not to have completed hand hygiene training, 21.7 per cent of staff had not completed manual handling training, and 13.1 per cent of staff were found not to have completed training in break away techniques. Other gaps in staff training relating to safeguarding and fire were previously outlined under Outcome 7 and Outcome 8.

The inspector found that arrangements in place in the designated centre for the

supervision of staff was not satisfactory. A review of supervision records for five staff members found that supervision meetings did not take place on a regular basis or on a quarterly basis as outlined as required in local organisational policy. In the case of one staff member, no supervision had taken place since April 2017 and two previous supervision records had stated dates of July 2016 and November 2015. In addition, the inspector found that arrangements in place for the ongoing or informal supervision of staff was not satisfactory.

The inspector reviewed four staff files held in the designated centre and found that these were compliant with the requirements as set out in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The person in charge confirmed that no volunteers were employed in the designated centre in the time since the last inspection.

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:

Thomas Hogan
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 Stewarts Care Limited
Centre ID:	OSV-0003908
Date of Inspection:	17 & 18 January 2018
Date of response:	27 February 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The arrangements for residents to freely access their own finances required improvement.

1. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably

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

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 shall be supported to open their own bank accounts. Where residents are supported to access their own finances, financial passports shall be developed to clearly outline the supports required. The finance policy has been reviewed to guide practice for staff in supporting residents.

Proposed Timescale: 30/06/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector found that systems in place for maintaining a log of all complaints and actions taken to address concerns was not satisfactory.

2. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The complaints policy has been reviewed to include a local complaints log. The complaints log has been circulated to all houses within the designated centre. Staff are being made aware that a complaint is an expression of dissatisfaction and should be processed as same, with local resolution where possible. The number of complaints officers has been increased to allow for the improved response to investigating of complaints. The complaints committee has been reviewed and their terms of reference approved by the CEO. The Complaints Committee reports directly to the CEO.

Proposed Timescale: 30/04/2018

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Fees to be incurred by residents for transport services were not set out in written agreements.

3. 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:
The finance policy shall be reviewed to reflect the charges incurred by residents. The Director of Care-Residents shall review all contracts of care. Where updates are required, contracts shall be updated. Contracts shall be signed by the resident and their family members.

Proposed Timescale: 30/06/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Full written agreements were not available for three residents who were availing of the services of the designated centre at the time of inspection.

4. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
The full written agreement has been uploaded to the residents file. An audit has taken place to ensure that all residents have full agreements on their file.

Proposed Timescale: 30/03/2018

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Arrangements had not been put in place to support a resident in achieving their personal goals.

5. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
The goals of the residents are reflected in the PATH plans. These have all been reviewed. All staff shall be trained in understanding their role as keyworkers. Where residents identify goals, the progress of these shall be monitored during monthly keyworking meetings. Goals shall be SMART to ensure they are measurable. The

person in charge shall review goals during regular audits of the personal support plans.

Proposed Timescale: 30/04/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Comprehensive assessments of need were not completed by an appropriate health care professional of the personal and social care needs of all residents on at least an annual basis.

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

Please state the actions you have taken or are planning to take:
An assessment of need tool shall be developed and carried out with each resident which shall include the health, personal and social care needs of the residents. This shall be completed prior to admission for new residents and no less than annually for current residents.

Proposed Timescale: 30/08/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not in place for all residents.

7. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
Every resident will have a personal plan in place.

Proposed Timescale: 26/02/2018

Theme: Effective Services

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

There was no evidence available to indicate that personal plans in place were reviewed on an annual basis.

8. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
The annual review of the support plan shall take place for all residents, coordinated by the Director of Nursing. This review shall include the effectiveness of the plans. The recommendations arising out of a review shall 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. Minutes of the review shall be recorded in the personal support plan of the resident and shall include all those who participated in the review.

Proposed Timescale: 30/08/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Painting and decorating was found to be required in areas of two units of the designated centre.

9. 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:
The person in charge shall carry out an environmental audit. Where maintenance work is required it shall be carried out.

Proposed Timescale: 30/04/2018

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:
There were not satisfactory arrangements in place in the designated centre for the identification and management of risk.

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:
The risk management policy will be reviewed and the policy will include systems for the assessment, management and ongoing review of risk, including a system for responding to emergencies within the designated centre. All staff will be inducted on the new policy.

Proposed Timescale: 30/06/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
An emergency fire exit, which was listed as being a "primary escape route" on the local emergency evacuation plan, was found not to be functioning internally at the time of inspection.

11. 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:
Where doors are marked as emergency exits on floor plans, Technical Services have ensured it is functioning.

Proposed Timescale: 31/01/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Six emergency fire exit routes across four of the individual units of the designated centre were found not to have emergency lighting in place at the time of inspection.

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:
The floor plans will be reviewed to ensure that all exits are appropriately marked. Where there are emergency exits, emergency lighting shall be installed in line with Fire Regulations.

Proposed Timescale: 30/05/2018

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:
30.4 per cent of staff members employed in the designated centre had not completed mandatory training in Safeguarding Vulnerable Persons.

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

Please state the actions you have taken or are planning to take:
The person in charge shall audit safeguarding training records. Where staff have not attended, they shall attend. Staff's understanding of this will be monitored through general governance, ie supervision, visits to house and monthly house meetings.

Proposed Timescale: 30/04/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Incidents of safeguarding concerns were not appropriately identified, reported or investigated in the designated centre.

14. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
All incidents shall be screened under the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policies and Procedures. There is a Designated Officer with responsibility for the Designated Centre to whom safeguarding concerns are raised. Preliminary screenings are completed for all concerns of abuse within time frames specified. The pathway for reporting concerns of abuse is on display in the designated centre. Regular audits of NIMS shall be carried out to ensure all incidents are identified, report and investigated. The person in charge shall submit weekly reports to the Programme Manager to ensure that all reporting is complete within the time frame.

Proposed Timescale: 30/04/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Health care support plans were not developed for a number of identified health care needs of residents in order to guide the practice of staff members in the provision of care.

15. 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:
The care planning process has been reviewed and a new format is being introduced to ensure that the health care needs have subsequent care plans in place. Training for all registered nurses has commenced on this new process with a completion date of end February 2018.
All health care needs will be discussed during monthly meetings and during on-site supervision of staff to ensure all staff are knowledgeable and plans guide practice.
Person in charge will request staff training in areas where required.

Proposed Timescale: 30/04/2018

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:
1. Improvements were required to ensure staff were clear on the rational for the administration of PRN emergency rescue medication.

2. A review of one medication cabinet in the designated centre found that one PRN medication (medication only taken as the need arises) was outside of the stated expiry date. A second PRN medication was found to have no expiry date available.

3. An anti-epilepsy medication was not administered as prescribed on one occasion and a medication prescribed for a skin condition was found not to have been administered as prescribed on several occasions.

16. 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:
The Policy on Medication Management has been reviewed to detail procedures for the ordering, receipt, prescribing, storing, disposal and administration of medicines.
All staff will be inducted in the policy and their understanding of the policy will be assessed.
An audit of all medicinal products shall be carried out and where medication has expired it shall be returned to the pharmacy.
All nurses within the designated centre shall carry out a competency assessment in the safe administration of medication. Where training supports are required they shall be provided.
The protocols shall be reviewed to ensure that they guide practice. The person in charge shall ensure that staff are aware and understand the protocols during supervision.
Monthly medication audits shall be carried out and any actions arising addressed.

Proposed Timescale: 30/04/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Keys to a medication cabinet in one area of the designated centre were observed to have been left unattended.

17. 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 have been informed that keys to the medication cabinet cannot be left unattended.

Proposed Timescale: 26/02/2018

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 arrangement for the person in charge to have significant responsibilities in other designated centres and in the wider organisation was found not to be appropriate.

18. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
The structure of the designated centre has been reconfigured to increase the number of persons in charge of the homes within the designated centre. The person in charge shall be responsible for no more than 3 homes.

Proposed Timescale: 30/04/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Completed six monthly unannounced visits to the designated centre were found not to be of a satisfactorily standard and did not identify concerns found at the time of inspection.

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

Please state the actions you have taken or are planning to take:
The registered provider has developed a schedule of unannounced inspections. The auditor meets with the Programme Manager/ CEO/ Director of Care-Residents on a monthly basis to give feedback on findings.

Proposed Timescale: 30/04/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was not clear if an annual report had been completed in the previous 12 month period as no date of completion was included on this document.

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

Please state the actions you have taken or are planning to take:
An annual review shall be published which will include date of review and date of publication.

Proposed Timescale: 30/04/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management system in place in the designated centre had not ensured that the service provided was appropriate to the needs of residents, consistently monitored, and action(s) taken to address identified concerns.

21. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The structure of the designated centre has been reconfigured to increase the number of persons in charge of the homes within the designated centre. The person in charge shall be responsible for no more than 3 homes. The person in charge reports to the Programme Manager who in reports to the Director of Care-Residents. The Director of Care-Residents reports to the Chief Executive. The person in charge shall on a weekly basis submit reports on incidents, notifications and progress on action plans. In the absence of the person in charge, an alternative person shall be identified as responsible for the monitoring of the service.

Proposed Timescale: 30/04/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management systems in place in the designated centre were not clearly defined at individual unit level.

22. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The structure of the designated centre has been reconfigured to increase the number of persons in charge of the homes within the designated centre. The person in charge

shall be responsible for no more than 3 homes. Care staff within the homes, report to the person in charge. The person in charge reports to the Programme Manager who in reports to the Director of Care-Residents. The Director of Care-Residents reports to the Chief Executive. The person in charge shall on a weekly basis submit reports on incidents, notifications and progress on action plans. A recruitment drive is underway to recruit social care workers to work within the designated centre and who will report directly to the person in charge.

Proposed Timescale: 30/04/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The number of staff on duty in three areas of the designated centre was below the minimum required levels as stated by the registered provider on a regular basis.

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

Please state the actions you have taken or are planning to take:
The person in charge has reviewed their staffing complement with the workforce planning office. Where deficits are identified, vacancies will be filled. A recruitment drive is underway to fill vacancies and in the interim agency staff will be utilised. Where additional staffing requirements are required, a business case has been submitted to the HSE.

Proposed Timescale: 30/04/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Significant gaps were found in staff training in all mandatory training categories

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:
The person in charge shall carry out an audit of all training records for all staff. Where gaps in mandatory training is identified, staff will be trained.

Proposed Timescale: 30/04/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised either formally or informally in the designated centre.

25. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
The structure of the designated centre has been reconfigured to increase the number of persons in charge of the homes within the designated centre. The person in charge shall be responsible for no more than 3 homes. The person in charge shall carry out formal supervision on a quarterly basis as per supervision policy. Informal supervision shall be carried out through visits to the homes within the designated centre.

Proposed Timescale: 30/04/2018