

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002442
Centre county:	Tipperary
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Carol Moore
Lead inspector:	Noelene Dowling
Support inspector(s):	Caroline Connelly;
Type of inspection	Announced
Number of residents on the date of inspection:	12
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 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:
28 April 2015 10:00	28 April 2015 20:00
29 April 2015 08:00	29 April 2015 16:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the second inspection of this centre which is designated as a centre for adults with severe to profound intellectual disabilities and challenging behaviors. The purpose of the inspection was to inform the decision of the Authority in relation to the application by the provider for the registration of the centre. All documentation required for the registration process was provided with the exception of written evidence of compliance with the statutory fire authority. The service is run by the Health Service Executive.

Inspectors observed practices and reviewed the documentation such as personal plans, medical records, accident logs, policies and procedures and staff files. A small

number of resident's questionnaires were received by the Authority prior to the inspection. In the main these expressed satisfaction with the care provided but the physical environment and the disruption created due to behaviour management was noted.

This inspection also reviewed the actions taken by the provider to address the improvements required following the previous inspection which took place on 6 and 7 May 2014. Of the 32 actions required following that inspection 12 had been satisfactorily completed, 13 had been partially completed and 7 had not been addressed satisfactorily. Matters not addressed included risk management procedures; fire safety training for staff; satisfactory review of resident's personal plans; consultation with resident and relatives; training in and management of safeguarding systems, the management of restrictive procedures; complaint management and ongoing maintenance of the premises.

As part of the registration process an interview was carried out with the provider nominee and the person in charge. An assistant director of nursing was being sought at the time of this inspection.

Staff were knowledgeable on the residents needs and were observed at all times to be calm in manner and respectful to the residents. The inspection found that residents received a good standard of health care with good medication management practices. Significant improvements had been made in the availability of permanent staff and to the number of persons available for on call support.

However, significant areas of non compliance were identified in the following areas;

- governance arrangements were not adequate
- implementation of risk management strategies was not adequate
- safeguarding training was not satisfactory
- systems to protect residents from abuse by peers were not satisfactory
- the management of behaviour and significant restrictive practices was not adequate
- crucial and consistent access to psychiatric and psychological intervention was not available
- satisfactory and consistent access to meaningful activities
- deployment of staff was not satisfactory
- there were no satisfactory systems for learning and review.
- annual multidisciplinary reviews of residents personal plans were not held
- development and implementation of the required policies was not satisfactory.

This centre has one unit which is located a significant distance from the main units. The location of and staffing levels in the unit were of particular concern due the high support needs of the residents.

The findings indicate that the provider and person in charge have not satisfactorily ensured that the centre can meet the needs of all residents at this time.

The actions required to achieve compliance with the Health Act (Care and Support of Residents in Designated Centres (Children and Adults) With Disabilities Regulations 2013 are outlined at the end of this report.

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

Outcome 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:

Inspectors were not satisfied that the systems used to promote resident rights were robust or sufficiently implemented in practice. A number of factors influence the findings in relation to compliance with this outcome including the complexity of the service user's needs and the deployment of staff between the units. On an individual basis staff supported residents with as much choice and control as possible by facilitating residents individual preferences for example in relation to their daily routine, meals and assisting residents in choice of activities or clothing.

Staff understood the residents means of expression including non verbal clues and were able to respond to their expressed preferences. Where it was necessary an advocate was appointed and social work support was also made available. One resident identified this to the inspector as very helpful to him. Some residents had specific transport schedules which were adhered to in order to ensure their activities were available to them.

Residents meetings had commenced in January 2015 in each of the houses and these were recorded in pictorial format with evidence of good interaction by the residents. Items on the agenda included food and activities. However, in some instances reasonable issues raised by residents such as the need for a new bed had not been addressed. Also raised was the disruption to some residents preferred routine due to behaviour and staffing levels. This was confirmed by the inspectors.

The action required following the previous inspection included the availability of the complaints process in a format that was accessible to the residents and this had been

completed.

However, the system for recording and managing complaints was not satisfactory. It was expected that staff would record complaints on a form on behalf of the residents and place these in a locked box in each house. As the CNMs did not visit the house furthest away regularly it could be up to seven days before the content of the box was noted. Staff were not clear on the process for managing or recording informal complaints which could be dealt with locally despite the detailed policy. Inspectors were informed that no complaints had been made.

There was no evidence that residents were involved in their personal planning although the content of the plans indicated a good knowledge by staff of the resident's needs and preferences. The plans had not been developed in a format which could be understood by the residents. The person in charge outlined a plan to provide "social story" formats suitable for the residents but this had not yet commenced. This is actioned under outcome 5 Social Care Needs.

There was evidence that staff maintained resident's dignity and privacy when carrying out personal care with doors closed and there was no sharing of shower or bathroom facilities. However, there were no locking mechanisms on some of the bathroom doors which compromises privacy.

It was noted that one female resident was accommodated with three males some of whom presented with challenging behaviours. This issues was not addressed in the residents personal plan and there was no evidence that the suitability this placement had been considered or the residents views sought on the arrangement.

As required by the previous inspection the policy on intimate care had been devised and directions in relation to this were evident on the personal plans provided. Gender issues were respected in the provision of such care.

At the previous inspection improvements were required in the systems for the appropriate usage of CCTV in one area of the centre. This had been addressed and here was a detailed policy which set specific limitations on its usage and privacy and dignity was maintained. From a review of the policy and the CCTV system inspectors were satisfied with the current arrangements and the reasons for it. This was detailed in the residents care plan.

The bedrooms held suitable space for storing clothing and other personal items with some residents belongings stored centrally. This was to accommodate the preferences of residents and in one instance in the interests of safety. Individual records of clothing and possessions were maintained. From a review of the management of resident monies inspectors were satisfied that transparent and monitored systems were in place.

There was no policy on residents' personal property, personal finances and possessions.

There was evidence that some residents ability to consistently participate in meaningful activities or attend day care was impacted upon by the need to provide additional support to other residents by virtue of their assessed need and behaviours. Planned

activities and normal routines were regularly deferred.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

By virtue of long standing relationships it was observed by inspectors that the staff understood the resident's preferences and the meaning behind their verbal and non verbal communication. Residents had access to televisions and staff were aware of, for example, their favourite television programs, music, activity or preferred clothing and routines. The personal plans held detailed communication strategies and these were found to be appropriate with the residents needs. Some staff did have sign language training and used this with residents who could not communicate.

Routines for a number of residents were outlined in pictorial format to ensure they were aware of what they were doing on any given day. Another resident who had a particular interest in cars had pictures of the staff cars and the day of the week in his room to ensure he would know who was coming on duty.

Judgment:

Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that there was a commitment to supporting and maintaining resident's familial and significant relationships. Visits to the centre took place and visits home were also supported by staff regularly. Residents who could communicate with the inspectors outlined how their family visits and relationships were supported. Where deemed necessary and in conjunction with other statutory services such contact was supervised appropriately.

Access to the community was evident with a resident working in a local store and some residents attending mass in the local community church and other locally based activities. A number are involved in a community swimming club. Suitable vehicles were available to enable residents go to local facilities. The location of the centre means that residents have easy access to local community, shops, transport and doctors and were observed accessing all of these during the inspection.

However, evidence of consultation with families in relation to residents personal planning and informing them of incidents was not consistently apparent. Staff informed inspectors that they would not necessarily inform families of incidents or injury. This is actioned under Outcome 5 Social Care Needs.

The visitor's room for one of the houses identified as an action at the previous inspection had not been made available as the provider intended to use the staff office which, given that it contains files, medication and equipment is not ideal. However, due to the small number of residents living in the house there is adequate communal space to accommodate this at various times. The residents also go home frequently as opposed to having visits in the house.

Judgment:

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 previous inspection by the Authority found that there were no contracts in care in place for residents. The person in charge informed inspectors that this matter had not yet been addressed and there were still no contracts of care for any resident in place. The person in charge advised that all residents' families were sent a letter and a copy of

the contact template on 21 April 2015. Inspectors viewed the proposed new contracts and found to be in compliance with the Regulations.

There were procedures in place for the management of admissions to the centre. The admission process as outlined included a detailed assessment of the resident based on agreed criteria. Referrals can be made from health care professionals. No new admissions had taken place for some years. There were documentary systems to ensure that if residents required admission or transfer to other services detailed information was available.

Judgment:

Non Compliant - Moderate

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:

From a review of eight residents medical and personal plans inspectors found that the care needs of residents were assessed and planned but significant improvements were required in the assessment and provision of care for residents psychological needs and ensuring that their social care needs were met. There was evidence of referral to allied services and evidenced based assessment tools used for falls, pressure areas and nutrition and communication. The assessment tools were regularly updated by staff. Referrals to and consultation with allied health services including speech and language, dieticians, physiotherapy, dentistry and optician services were evident. The interventions were documented in the resident's plans.

Residents personal goals, social preferences, communication needs were also documented and activities planned accordingly. However, the multidisciplinary annual review of the resident's personal plans had taken place for only one resident. There was evidence that the provider had commenced the process of inviting families and next of kin to attend this review meeting. There was no evidence that up to now they had been consulted and involved in the resident's personal planning process. The personal plans

seen were very detailed and covered a range of health care, social care and behavioural needs. There was detailed information available to hand should a resident require transfer to acute care or other services.

However, there was a significant deficit found in the assessment and interventions for resident's psychological well-being and treatment. Inspectors found that this impacted on the capacity of the key workers and the person in charge to provide a comprehensive personal plan based on full assessment and with multidisciplinary input. For some of the most vulnerable residents with a complexity of psychological needs this deficit was significant and could be seen to impact on their quality of life. This was evident by the restrictions placed on them and lack of suitable activities. Inspectors acknowledge the efforts of staff to provide care but they were doing so without adequate guidance and fully acknowledged this.

As a result of this inspectors were concerned that due to the level of behaviours presented, lack of adequate staffing in some instances and lack of satisfactory multidisciplinary review the provider had not made sufficient arrangements to ensure that the needs of all of the residents could be met.

It was apparent that due to the staffing shortages the personal plans were not always adhered to in terms of social care needs and activities. Some were cancelled and not followed through as there had been a deficit in key workers to do so. The effectiveness of the plans and the outcomes for some residents could not be adequately assessed. Day care activities had been significantly reduced and were not structured so as to ensure all residents had access to suitable planned services. For example, one resident had expressed the view that she no longer enjoyed the day care option available. No other options had been explored.

There was no end of life policy developed and implemented. Staff informed inspectors that it was their hope in the event of a resident requiring such care that they would be able to facilitate this in the resident's home. No plans for how this would be achieved had been discussed.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The centre was opened in 1995 and comprised of three residential houses which cater for adult residents with severe to profound intellectual disability and one of the houses caters for residents who also have physical disability. The first premises was a detached bungalow catering to the needs of four service users within the range of moderate to severe/profound intellectual disability and behaviour that challenges. There were three bedrooms and a one self contained purpose built apartment occupied by one resident which is secured on occasion. This apartment consisted of a bedroom, kitchen, bathroom, dining room, activity room and separate access to the garden. All doors into and within this premises were locked and all staff had keys. The administration and managers offices are also located in this house.

The second premises was a detached bungalow adjacent to the first house and could accommodate five residents within the range of severe to profound intellectual and physical disability. The third premises catered for the needs of four residents within the range of moderate to severe intellectual disability with challenging behaviours'. There is also a small apartment in this house which is locked for safety reasons on occasions. There were adequate sitting, recreational and dining space separate to the residents' private accommodation and separate communal areas.

There was a sufficient number of toilets and bathrooms for the residents. One of the houses has suitably equipped en suite rooms which were of a good size and could accommodate residents who required assistive equipment easily. All residents had single bedrooms. Residents to whom inspectors spoke with said they enjoyed having their own room. Inspectors viewed a number of residents' bedrooms and noted most had personalised their rooms with photographs of family and friends and some personal furniture and memorabilia except where the environment was dictated by the safety needs of the residents.

All had suitable and in some instances secure garden areas with seating and suitable lighting. One of houses had suitable wheelchair access for the residents who required this. Some but not all of the actions required from the previous inspection had had been addressed including renovation and paint work in all houses and replacement of furnishings and fittings. This had made a significant improvement.

However, basic requirements such as grab rails had not been provided in the hallways as required where the residents had significant mobility issues. A hand rail was installed in the wrong en suite in 2014 and this had not been altered in the intervening period.

There were deficits in the timely maintenance and repair of facilities to ensure they were suitable and available to the residents. One shower was out of order for some time, a medi-bath used by a dependant resident had not been repaired for one year and a shower hoist for a resident, recommended in January 2015 had not been procured. The resident was required to have bed-baths for four months preceding the inspection.

The house located furthest away was considered "offsite" therefore there were

considerable delays in maintenance being carried out. This included the necessary remedial works on the septic tank. Inspectors noted a broken door handle which posed a risk to residents as it was jagged at the edges. Staff informed inspectors that this would take at least two weeks to be rectified.

The environment in one house was seen to be especially sparse and devoid of any features which would make it more homely and comfortable. This cannot be entirely explained by virtue of the resident's behaviour as options such as secure and unbreakable glass, for example in pictures, is available. Such options to improve the overall environment safely had not been satisfactorily explored.

Other equipment used by residents including wheelchairs were serviced and the vehicle was also serviced regularly and insured.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

While some actions from the previous inspection had been completed improvements were still required in the management of risk and systems for learning and review from incident and accidents. The combined risk management and health and safety documentation seen by the inspectors contained details of the safety issues required by the regulations. While there was a risk register in place it did not satisfactorily demonstrate that risks were pro actively assessed taking the complexity of residents needs into account and the distance of one of houses from timely support.

Each resident had a risk assessment completed which governed a number of issues such as medical needs, physical and behavioural limitations, building hazards, activities of daily living. The assessments focused on individual residents' needs for example issues with medication or potential for falls.

Some actions from the previous report had been addressed. Each resident had a detailed personal evacuation plan in an easily accessible location and staff were familiar with these plans. Records available demonstrated that the fire alarm and emergency lighting had been serviced annually and quarterly as required. Regular fire drills had been held in each of the houses and the outcomes noted. Staff were undertaking documentary daily checks of the fire exits and alarm panels and a visitors log was maintained for evacuation purposes. A fire safety review of the premises had been

undertaken 2104 by the HSE although the provider stated that no report of this was yet available.

However, a number of deficits in relation to fire safety were again found:

- fire training was out of date for up to 17 of the staff.
- significant fire doors including the kitchen in one house was found wedged open.
- written evidence of compliance with the statutory fire Authority had not been made available for the purposes of registration.

While clinical waste was managed satisfactorily issues were again identified in the control of infection with

- faecal matter seen in one residents shower and on the shower room floor at 14:30hrs.
- a chair with unsuitable torn covering was being used in one shower room.

Other risks identified included a significant number of chemicals stored in an unlocked able room which residents had easy access to.

From a review of the accident and incident records inspectors were not satisfied that there was a coherent strategy for the implementation of remedial actions and learning and review from untoward events. Incidents not reviewed in a timely manner in some case months after the event to implement strategies for prevention of a re-occurrence. These included assaults and medication incidents.

It was apparent to the inspectors from documentation and interviews that strategies were not consistently adhered to by staff. For example, despite a seating plan on the transport staff did not consistently adhere to this which resulted in further assaults on residents. Reside were brought to locations deemed not suitable for them which also resulted in incidents. Despite the existence of the health and safety committee there was no cohesive procedure for the management of risk which translated into practice across the houses.

Judgment:

Non Compliant - Major

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:

Inspectors reviewed the policy and procedure for the safeguarding of vulnerable adults and persons with disabilities which is the revised HSE policy issued in 2014. The person in charge was the designated officer. However, training had not been provided to her on the implementation of this policy and her function. The inspector was informed that this was scheduled for May 2015.

Inspectors saw evidence that the provider had taken appropriate steps in any situations which required external reporting and had accessed the relevant authorities and put protective measures in place where these were assessed as necessary. However, the training records demonstrated that only 11 staff had undergone training in the protection of vulnerable adults since 2012. While some staff were very clear on the symptoms and signs of abuse and the reporting mechanism and responsibilities some were not.

Inspectors were not satisfied that there were systems in place and adhered to protect residents from abuse by their peers. The inspectors noted seven recorded incidents of peer to peer physical abuse. The circumstances and severity varied but in the inspectors view four of these incidents were definite physical assaults which had not been adequately addressed or reviewed. Parents were not informed. Staff told the inspectors that it was not standard practice to notify next of kin or families of incidents. These had not been reported to the Authority as required. From speaking with the person in charge there was no clarity as to whether such incidents should be classified as abusive.

There was no policy on the management of behaviours that challenge. The statement of purpose indicates that management of a high degree of challenging behaviours is an integral part of this service. There were detailed behaviour management plans in place. Staff demonstrated competence, calmness, knowledge of the presenting behaviours and the meaning behind them for the residents. A behaviour specialist nurse had recently been appointed to provide support and advice to staff.

Some practices were seen to be effective and also supported residents to manage their own behaviours. For example, when sharp knives were being used in the kitchen, a red sign was placed on the door to remind a resident not to enter as there had been incidents with knives. From a review of the use of PRN medication for the management of behaviours inspectors were satisfied that this was not a feature of the behavioural supports being used.

The actions from the previous inspection were in relation to the detail in personal plans of the use of restrictive practice, alternatives, defined circumstances for use, time frames and evidence of consultation with families in relation to this. Inspectors were satisfied that these documentary deficits had been addressed.

However, in some instances very restrictive measures had been implemented including the locking doors for specific time periods in defined circumstances in the individual apartments and one of the houses. Some effective strategies had been implemented including the provision of individual transport for two residents to ensure their needs for activation and change out of the restrictive environment was met which could be seen

to reduce incidents.

One of the environments was observed to be particularly sparse and contained safety features including secured furniture. These arrangements were defined as single separation. The residents were not entirely secluded and had access to staff and other residents if they choose and in defined circumstances.

There were improvements required in the staffing levels and clinical overview of the practices used. Significant inconsistencies were observed in the staffing levels in the houses with one adhering to a satisfactory staff ratio for the provision of high support care.

However, this was not evident in the second house where behaviours posed threats to other residents and required a high level of staff supervision and intervention. Only two staff were available on occasions and the records indicated that incidents persisted. This house was located 15km distance from the other two houses which resulted in no available additional support in such a crisis.

Inspectors saw records and were informed by staff that it was impossible to leave one staff to even access the prescribed PRN medication or to provide care to the other residents in some instances due to staffing shortages

None of the strategies employed or the locking of doors had been reviewed to ensure they remained suitable, safe and effective. A strategy employed to avoid assault on other residents was not adhered to by staff on all occasions.

No multidisciplinary review of one resident's behaviour plan and secluded accommodation had taken place in over a twelve month period. Inspectors could not ascertain the assessment process, clinical rationale and prescriptions which instigated these procedures. In addition, and of more concern was the lack of clinical review and intervention available consistently to the staff in regard to their continued use.

Where psychological intervention had taken a place on a once off consultancy basis there was no report available to staff to guide their practice. It was apparent that other residents were impacted both by virtue of assaults and limitations placed on their routines because of some behaviours and the lack of adequate clinical support to guide practice and safeguard all residents. This is also actioned elsewhere in this report.

Judgment:

Non Compliant - Major

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:

From a review of the accident and incident logs and the notifications forwarded to the Authority the inspectors were not satisfied that the person in charge was complying with the requirement to notify the Office of the Chief Inspector of any accidents or incident which occurred in the centre. These deficits included notifications of abuse and restraint procedures used in the centre.

Judgment:

Non Compliant - Major

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Inspectors observed that opportunities for development and activation were impacted upon by the staffing levels, behaviours and changes made in recent years to the day service. Some individual activities' took place including baking, board games, horse riding and life skill training and residents went shopping and to local amenities. One resident worked in a local store part time and another in the campus laundry.

Inspectors were informed that the day service staffing had been reduced to one person in recent years. This resulted in a drop in the number of days and type of activities available to the residents. Staff from the houses had to accompany and remain in the day service with residents. If this was not possible due to illness or the behaviour of residents the remaining residents could not access the services. The arrangements were much unstructured. On other occasions residents had to return early from the day service as the day service staff had other duties including planning for staff training and

meeting service users from the community. The person in charge stated that although this service was under her remit it had not been reviewed for some time.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Inspectors were satisfied that resident's healthcare needs were met but there were areas for improvement required in access to other services in particular psychological and psychiatric interventions. These are actioned under Safeguarding and Safety and Social Care Needs.

There was very good access to general practitioners (GP) services both in the centre and in the GPs surgery. A range of allied health services were available including occupational therapy, speech and language therapy and dentistry and opticians. The interventions identified by the clinicians were detailed in the care plans and staff were seen to be knowledgeable in relation to them. The inspectors noted that the daily records maintained by staff were very detailed and indicated that staff were observant and responded quickly to any changes in resident's health.

There were strategies in place to encourage healthy eating, diets and health promotion with staff and residents agreeing on food choices and weight management strategies. Appropriate assistance was provided for residents. All catering and food shopping was undertaken in the individual houses and some residents participated in this where it was assessed as suitable and safe for them to do so. There was evidence that the advice of dieticians was sought and resident's weights and fluids were monitored where required. A number of residents had specialised dietary requirements or required modified diets and these were seen to be adhered to. The food available was varied. Where possible residents participated in the preparation of food. However inspectors observed that due to the fact that no menus or records of the evening meal was maintained it was possible that the residents would receive the same meal several times during the week inadvertently. Staff concurred with this finding.

There was no end of life policy developed and implemented. Staff informed inspectors that it was their hope in the event of a resident requiring such care that they would be able to facilitate this in the resident's home. No plans for how this would be achieved

had been discussed.

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):

No actions were required from the previous inspection.

Findings:

The inspectors saw that the residents own GP generally prescribes all residents medication and this is obtained from a local pharmacist for each resident. The houses all had medication supplied in individual boxes and bottles labelled for each resident. Medications were seen to be stored securely in a locked cupboard in the offices which were all secured. There was no excess medication stock and staff said that if any medications were not required or were out of date they were immediately returned to the pharmacy.

The centre provided a nurse led service so medication administration was only undertaken by nursing staff. Staff that the inspectors spoke to demonstrated an understanding of appropriate medication management and adherence to professional guidelines and regulatory requirements. The staff told the inspectors that the pharmacist gives advice to the residents and staff in relation to the medications provided. The inspectors saw that medication errors, incidents were recorded in accordance with legislative requirements and there was evidence of an audit of medication management undertaken by the CNM in the houses. However as will be outlined further in outcome 14 the whole area of auditing of practice required review and improvement to record any remedial actions having been taken and enhance outcomes for residents.

The prescription sheets reviewed by the inspectors were clear and distinguished between PRN (as required), short-term and regular medication. They contained photographic identification of the residents. Maximum dosage was prescribed for all PRN medications. There were no residents having crushed medications as the centre secured liquid medications where possible. There were no residents that required scheduled controlled drugs at the time of the inspection and the inspectors noted that although there were high levels of PRN medications prescribed there was not high levels of PRN medication being used and PRN appeared to be used as a last resort.

The GP reviewed and re wrote the medication charts on a three monthly basis, however the inspectors noted that a number of residents were on high doses of psychiatric medications and as outlined previously there was a lack of an ongoing review by the

psychiatrist of these complex medication prescriptions and plans.

There were centre-specific medication management policies and procedures in place which were viewed by the inspectors and although they were found to be comprehensive they remained in draft format as they had been at the previous inspection. The person in charge said they were to be signed off on and training on the policy was to be provided to all staff but this had occurred to date. This is actioned under Outcome 18 Records.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The statement of purpose was not fully compliant with the regulations with an improvement required in the details of the services to be provided, arrangements for admissions and reviews of the personal plans. The staffing levels, risk management procedures and location of one of the houses did not demonstrate that the statement was currently being complied with.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Inspectors acknowledge that since the previous inspection the provider has made changes to staffing arrangements and levels, satisfactory on call and additional clinical nurse managers in order to provide sufficient care and overview.

In March of this year the provider commissioned a quality review by an external consultant who undertook a visit to the centre on behalf of the provider. This review advised the setting up of a rights review committee. Inspectors were informed that this was being considered. The provider also informed the inspectors she intends to undertake further unannounced visits to the centre and develop a template to ensure the visits are effective. This will support the provision of the required annual report.

The person in charge was suitably qualified and experienced. However she was also the person in charge of two other designated centres within the organisation and allocated a considerable distance away. Given the findings in this centre this arrangement should be reviewed and this was discussed with the provider at the feedback meeting.

Arrangement for communication and reporting required some improvements to ensure satisfactory sharing of information between the person in charge and the provider. For example, the provider was not aware that the clinical nurse managers were not visiting the outlying house.

However, despite the revised on-call and management arrangements there was evidence of insufficient monitoring of the care delivered. A number of clinical nurse managers have been appointed. However, the hours of work and the functions had not been devolved to provide management and support over the full week. The impact of this was most apparent in the house which is located a significant distance from the other two houses and the offices. From interviews it was apparent that this house was only attended by a manager sometimes on a fortnightly basis which is not sufficient.

The roster for the CNMs resulted in significant management cover some days per week and none on others. There is a regional clinical nurse manager whose function is to visit the houses occasionally but there is no reporting mechanism for this. There was no effective arrangement in place to supervise and performance manage all members of the workforce to exercise their personal and professional responsibility. A detailed induction programme had been developed as required. The staff supervision system had not been implemented.

There was no evidence that any accidents or incidents were reviewed effectively and remedial actions taken to prevent re-occurrences by the person in charge. Standard procedures such as audits of practices including medication had not been implemented. Despite detailed records being available no system had as yet been devised to undertake an effective review of incidents to facilitate learning and development. No surveys of residents or relatives had been undertaken.

The overall findings of the report in terms of risk management, safeguarding, restrictive practices and access to psychological services, staff training, staffing, review of safety of care and the staffing and governance of the outlying house and compliance with the requirements to notify the authority indicate that the current management systems were not sufficient to ensure the safety and appropriateness of the service.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

There was a CNM 11 nominated to take charge of the centre and deputise in any absence of the person in charge including annual leave and any absences which requires notification to the Authority. The person was suitably qualified, the required documentation had been forwarded to the Authority and the arrangements were satisfactory. The provider was in the process of recruitment a fulltime assistant director of nursing who it is expected will act in the absence of the person in charge

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

From a review of the service, records and interviews the inspectors were satisfied that sufficient resources including adequate heating, transport, food were in place and well utilised. The availability and deployment of staff is discussed in Outcome 17 Workforce and the timely access to maintenance for the centre is also not satisfactory.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Inspectors were satisfied that the provider had made some improvements in terms of the staffing complement and continuity of care. However, there were gaps still evident in the deployment of staff at all grades to ensure there was sufficient staff to provide and supervise care.

The last inspection found that agency staff was regularly required in the service to maintain staffing levels. This impacted on residents in terms of continuity of care. The person in charge informed inspectors that the use of agency staff had been reduced significantly. This was supported by documentary evidence which detailed the use of agency staff on a weekly basis. The average number of agency nursing staff in the past four months was 94. A core group of agency staff had been nominated to support better continuity of care. The inspectors were informed that a total of five nursing staff had been recruited in February 2015.

The needs of the residents indicate that nursing presence is required at all times. However, one of the houses located furthest away was regularly scheduled to have only two staff on duty. Rosters reviewed and interviews with staff confirmed that a nurse was not consistently deployed to this unit. Two staff are insufficient for the behaviours and support which the residents require. Incidents reports, meeting records and interviews with staff verified this finding.

Inspectors reviewed the new staff induction arrangements which were also required by the previous inspection. All new staff were given an induction by a member of

management which covered topics such as policies and procedures, philosophy of care and day and night routines in the centre.

The induction documentation stated that eight nurses and seven care assistants had completed the induction at the time of inspection. The process included supernumery time. There is no supervision arrangement for staff however. There was no housekeeping or catering staff employed so staff were responsible for all cooking and day to day cleaning. Given the needs and behaviour of the residents this was not a satisfactory allocation of staff.

The previous inspection found that there was a failure to ensure staff had access to appropriate training, including refresher training, as part of a continuous professional development program. Inspectors found that this had not been adequately addressed. As stated previously, training in abuse had not taken place for 11 staff since June 201. Fire training was also out of date for staff.

Training in manual handling and MAPA (Management of Violence and Aggression) has been undertaken for all staff. The staff group had training in different disciplines including psychiatric nursing, intellectual disability nursing, social care and Fetac level 5. Documentation of training was poorly maintained.

A sample of personnel files were reviewed by inspectors. While most of the files contained all of the information required by Schedule 2 of the Regulations, there were a number of shortcomings. For example, the file for a care assistant did not have a details or documentary evidence of a recent relevant qualification they had attained. In addition, the file for a member of management did not contain a reference from their most recent employer and did not give an explanation for this.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

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

implemented.

Findings:

The inspector found that records in relation to residents were complete and detailed.

The directory of residents was in compliance with the regulations and the residents guide required by the previous inspection had been compiled. However, improvements were identified in relation to the policies required by schedule 5. A number were not in place and those that were had not been implemented.

An up-to-date insurance policy was in place for the centre which was in accordance with the HSE policy.

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:

Noelene Dowling
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 Health Service Executive
Centre ID:	OSV-0002442
Date of Inspection:	28 April 2015
Date of response:	02 June 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

There was no evidence that residents or their representatives were involved in their personal planning.

Action Required:

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability,

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

participates in and consents, with supports where necessary, to decisions about his or her care and support

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

12 of the residents and families have been invited to attend an Annual Review of each residents PCP. 11 PCP's have now been completed.

1 is outstanding as it had been scheduled for 20/05/15 but had to be rescheduled for 04/06/15.

Minutes of these meetings will reflect the attendance, discussion and actions arising.

Proposed Timescale: 04/06/2015

Theme: Individualised Supports and Care

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

Failure to review the suitability of the placement for a resident or elicit the residents or relatives views on the arrangement.

Action Required:

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

1) This placement was discussed at a Local Management Team Meetings (LMT) on 06/05/15 to look at possible alternative accommodation options. The overall compatibility of 8 residents within the service is presently being reviewed by a Consultant Psychologist and recommendations will then be discussed with management.

2) Staff have researched the availability of more suitable accommodation nearer to the main centre which might be available pending the outcome of the review by Consultant Psychologist

3) In the future the minutes of the Annual Reviews of PCP's will reflect discussion in relation to suitability of a placement.

1. Awaiting confirmation from Clinical Psychologist to inform decisions regarding accommodation options and management will be informed on or before 30/06/15. 2. Commenced and ongoing. 3. As relevant in the future as part as PCP process.

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

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

Failing to ensure that reasonable issues raised by residents in relation to their care needs are addressed..

Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

1) An interim plan for improved governance of the services has been implemented since 25/05/15 to support the managers to ensure timely and appropriate follow-up to issues raised by residents. The interim plan is as follows;

3 CNM2's will work 3 x 12 hours days per week. This will cover 7 days in conjunction with the shifts worked by the 2 CNM1's who work frontline in the houses

Each of the CNM2's will be allocated a house and will be the identifiable manager for that house and be responsible for follow up on issues relating to that house and the service users living in the house. The interim plan allows the CNM2's to ensure that issues raised by residents in relation to their care needs are addressed.

Proposed Timescale: 25/05/2015

Theme: Individualised Supports and Care

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

Failing to ensure that all residents could consistently participate in meaningful activities or attend day care.

Action Required:

Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

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

1. Additional staff have been requested and approved temporarily to provide 1 to 1 support for 2 residents to support activation for defined periods during the week. This will allow for increased activation for all residents.
2. Residents of 2 houses are being referred to Consultant Psychologist for review in relation to living arrangements and collective planning of daily activities between these service users. The recommendations of the psychologist are awaited.
3. The day service has completed the New Directions Benchmarking Tool 2015 of the HSE which will inform and support management of progress in implementing New Directions, in particular against the core values of Person Centredness, Community Inclusion and Active Citizenship and Quality. The Guidance Officer met with Day Services Manager and CNS on 22/05/15 regarding additional opportunities for activation that could be explored. A process of review of individual residents activation needs will continue.

4. A business case for the ongoing provision of improved staffing resources will be finalised when recommendations of the Consultant psychologist are available.
Proposed Timescale: 1. Commenced 2. Commenced 3. Commenced. 4. 30/06/15 pending recommendations being available

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

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

Current system for the reporting of complaints are not satisfactory to ensure a prompt review.

Action Required:

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

CNM2's will actively review daily progress notes / minutes of residents house meetings etc to ensure complaints are noted and resolved or referred to designated complaints person as per local policy.
Immediate and ongoing.

Proposed Timescale:

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Residents had no contracts of care.

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:

4 have been signed.

1) 7 have to be returned by families expected 11/06/15.

2) 1 is being followed up by DON with Ward Of Court Office

11/06/15 pending families cooperation 2. As soon as possible with cooperation of Ward of Court Office.

Proposed Timescale: 11/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

Residents social care needs as detailed in their plans were not consistently met due to staffing and resourcing.

Action Required:

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

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

1. Additional staff have been requested and approved temporarily to provide 1 to 1 support for 2 service users to support activation for defined periods during the week. This will allow for increased activation for all residents.

2. A Consultant Psychologist is presently reviewing living arrangements and collective planning of daily activities between the residents of 2 houses. A business case for the ongoing provision of improved staffing resources will be finalised when recommendations of the Consultant Psychologist are available.

1. Commenced 2. 30/06/15 pending recommendations being available from Consultant psychologist.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

There were no assessments and interventions and personal planning for resident's psychological well-being.

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:

1) The suitability of the service to meet the needs of one resident is being reviewed by a Consultant Psychologist in addition to the compatibility of 8 residents and their living circumstances.

2) A Psychologist for the service has been sanctioned and the post will be filled as soon as possible. Efforts to continue to source sessional psychology services in the interim

will be ongoing between the Centre and the Psychology Department.

1. By 30/06/15 or sooner if available. 2. As soon as recruitment can fill the post.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Not ensuring that staffing levels, behavioural support, assessments and interventions were sufficient to ensure that the needs of all of the residents could be met within the current environment.

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:

1) The Consultant Psychiatrist for Disability Services has been requested to review the resident's needs for psychiatric inputs/support and revert with advice.

2) SLT requirements are being addressed by SLT Manager and will be provided as required.

3) The services of a Consultant Psychologist have been secured to advise on the suitability of the service to meet the needs of an individual. A private service provider has been put on notice, to look at costing a service for the individual to ensure access to all the therapeutic supports required, should the HSE not be able to provide same.

4) A Psychologist for the service has been sanctioned and the post will be filled as soon as possible. Efforts to continue to source sessional psychology services in the interim will ongoing between the centre and the Psychology Department.

5) A business case for the ongoing provision of improved staffing resources will be finalised when recommendations of the Consultant psychologist are available.

Proposed Timescale: 1. Commenced. 2. Commenced. 3. Commenced

4. As soon as recruitment can fill the post. 5. 30/06/15 pending recommendations being available.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Residents and or their representatives had not been consulted and involved in the personal planning process.

Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and

where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

12 of the residents and families have been invited to attend an Annual Review of each resident's PCP. 11 PCP's have now been completed.

1 is outstanding as it had been scheduled for 20/5/15 but had to be rescheduled for 4/6/15.

Minutes of these meetings will reflect the attendance, discussion and actions arising.
Proposed Timescale: 04/06/15 and annually thereafter

Proposed Timescale: 04/06/2015

Theme: Effective Services

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

The effectiveness of the personal plans and the outcomes for some residents were not adequately assessed.

Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

1) An interim plan for improved governance of the service has been implemented since 25/05/15 ie 3 CNM2's will work 3 x 12 hours days per week. This will cover 7 days in conjunction with the shifts worked by the 2 CNM1's who work frontline in the houses. Each of the CNM2's will be allocated a house and will be the identifiable manager for appropriate follow-up regarding the effectiveness of each residents PCP. Each plan will be evaluated on a quarterly basis for progress. Minutes of annual and quarterly review will reflect the evaluation of effectiveness of PCP's.

2) Additional staff have been requested and approved temporarily to provide 1 to 1 support for 2 service users to support activation for defined periods during the week. This will allow for increased activation for all residents.

1. Commenced 2. Commenced

Proposed Timescale:

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

No ensuring that maintenance, repair of the premises and replacement of equipment and the premises was undertaken in a timely manner.

Action Required:

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

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

1. Resources have been specifically allocated to progress maintenance issues .The majority of maintenance issues outstanding at time of inspection have been addressed.
2. The interim plan for improved governance of the service which has been implemented since 25/05/15 ie 3 CNM2's will work 3 x 12 hours days per week. This will cover 7 days in conjunction with the shifts worked by the 2 CNM1's who work frontline in the houses. Each of the CNM2's will be allocated a house and will be the identifiable manager and will allow time to follow up on maintenance requirements in each house in a timely manner.
3. The requirement for ongoing available funding to prioritise maintenance issues has been highlighted through the line management structure for prioritisation.
 1. Specific issues outstanding at time of inspection prioritised and all to be finalised by 12/06/15 assuming delivery of parts required.
 2. 25/05/16.
 3. Done

Proposed Timescale: 12/06/2015

Theme: Effective Services

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

Not ensuring that basic requirements such as grab rails in corridors and bathrooms were provided in the hallways as required where the residents had significant mobility issues.

Action Required:

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

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

1. Grab rails in bathroom are in situ.
2. Mobility assessments have been requested as a priority from Physiotherapy Dept. regarding the grab rails in the hallway and will be fitted immediately thereafter.
 1. complete
 2. Assessment awaited by Physiotherapist and immediately thereafter.

Proposed Timescale: 02/06/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

There was no coherent strategy for the assessment of risk and implementation of remedial actions to manage risk.

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:

- 1) Set agenda for LMT meetings held on a monthly basis (CNM2's, CNS, Day Service Manager, DON and CNM1's as available) to include ongoing review of risks and incidents.
- 2) Set agenda for meeting between DON and Disability Manager and/or Operations Manager to include the assessment of risk and implementation of remedial actions to manage risk.
- 3) Risk Register will continue to be utilised to identify issues outside of local control. Will be ongoing monthly

Proposed Timescale: 06/05/2015

Theme: Effective Services

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

There was no system for learning and review from accidents and incidents.

Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

- 1) Set agenda for LMT meetings held monthly (CNM2's, CNS, Day Service manager, DON and CNM1's as available) to include ongoing review of risks and incidents.
- 2) Template for recording and reviewing accidents and incidents has been developed.
- 3) Set agenda for meeting between DON and Disability Manager and/or Operations

Manager to include review of accidents and incidents monthly.

Risk Register will continue to be utilised to identify issues outside of local control.

1. Completed 06/05/15
2. Will be in use from 10/06/15
3. 11/6/15

Proposed Timescale: 11/06/2015

Theme: Effective Services

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

To ensure that the premises was kept suitably clean and that all equipment used was suitable to prevent infection.

Action Required:

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

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

1. Unsuitable equipment has been removed/replaced
2. A schedule for cleaning the specific area which staff have limited access to has been implemented

Proposed Timescale: 02/06/2015

Theme: Effective Services

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

Failure to ensure that staff had fire training which was out of date for up to 17 of the staff.

Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

- 1) 14 of the 17 have completed training on 28/5/15
- 2) 3 outstanding will complete training on 4/6/15

Proposed Timescale: 04/06/2015

Theme: Effective Services

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

Failure to ensure fire management systems were satisfactory with significant fire doors including the kitchen in one house was found wedged open.

Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

- 1) Staff have been instructed to never hold or wedge fire doors open.
- 2) The recommendations of the draft fire audit will be available by 04/06/15.

Proposed Timescale: 04/06/2015

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:

Failing to ensure restrictive strategies employed including, but not exclusive to the locking of doors or single separation had been reviewed by appropriately qualified persons to ensure they were suitable, safe and beneficial to the resident well being.

Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

- 1) Consultant Psychologist is reviewing the use of single separation as part of his overall assessment of one resident.
 - 2) An MDT meeting is currently being arranged to review practices in relation to the use of restrictive interventions.
 - 3) Meeting held by DON and Disability Manager to agree Terms of Reference for Rights Review Committee and identify potential committee members. One meeting held with a committee member who has agreed to sit as an external member on the Rights Committee (22/05/15)
1. Assessment commenced on 09/05/15. 2. Date to be confirmed. 3. Rights Review Committee to be set up by 31/08/15.

Proposed Timescale: 31/08/2015

Theme: Safe Services

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

Not ensuring that there was a policy in place on the management of challenging behaviours to guide staff in their actions.

Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

1) Policy in draft and will be reviewed by managers, approved and ready for staff training 19/06/15

Proposed Timescale: 19/06/2015

Theme: Safe Services

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

Failure to ensure that restrictive intervention were satisfactorily reviewed.

Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

4) Consultant Psychologist is reviewing the use of single separation as part of his overall assessment of one resident.

5) An MDT meeting is currently being arranged to review practices in relation to the use of restrictive interventions.

6) Meeting held by DON and Disability Manager to agree Terms of Reference for Rights Review Committee and identify potential committee members. One meeting held with a committee member who has agreed to sit as an external member on the Rights Committee (22/05/15)

1. Assessment commenced on 09/05/15. 2. Date to be confirmed. 3. Rights Review Committee to be set up by 31/08/15.

Proposed Timescale: 31/08/2015

Theme: Safe Services

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

Not ensuring that restrictive interventions were applied in accordance with national policy.

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:

1) Every effort to ensure that restrictive interventions are applied in accordance with national policy is being made with the sourcing of a sessional psychologist and the sanctioning and filling of the psychology post.

Proposed Timescale: 09/05/2015

Theme: Safe Services

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

Failure to ensure that there were systems including adequate staffing and supervision in place and adhered to protect residents from abuse by their peers.

Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

1) Additional staff had been requested and approved temporarily to provide 1 to 1 support for 2 service users to support activation for defined periods during the week. This also has the effect of protecting their peers from abuse. However due to deficits in availability of agency staff this has not always been possible.
2) A business case for the ongoing provision of improved staffing resources will be finalised when recommendations of the Consultant psychologist are available.
1. In situ. 2. 30/06/15 pending the availability of psychologist's recommendations.

Proposed Timescale:

Theme: Safe Services

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

Failure to take appropriate measures where resident were abused by peers.

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:

- 1) Review by consultant psychologist as advised above will inform regarding compatibility and activation
 - 2) Safeguarding plans are in place for any service user who has been abused by a peer.
 - 3) A local procedure for the implementation of the HSE Policy for Safeguarding of Vulnerable Adults has been developed. Training of staff to follow.
 - 4) Notification forms from 01/11/13 to-date will be sent to HIQA by 02/06/15
1. Awaiting report of Psychologist
 2. Complete
 3. 29/05/15 and training is scheduled to be completed by 27/07/15.
 4. 02/06/15

Proposed Timescale: 27/07/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Residents limited opportunities to access meaningful activities.

Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

- 1) Meeting with Guidance Officer held on 22/05/15 with Day Services Manager and CNS to explore additional opportunities to access meaningful activities and will be followed up.

Proposed Timescale: 22/05/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There was no policy on end life care provision.

Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

1) Draft policy developed for discussion with GP's, staff and management will be available 10/06/15

Proposed Timescale: 10/06/2015

Theme: Health and Development

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

Due to the lack of menus or records of the evening meal it was possible that the residents would receive the same meal several times during the week inadvertently.

Action Required:

Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

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

- 1) Weekly menus are decided at weekly house meeting
- 2) By use of visual/pictorial menu residents are informed daily of what is on the menu.

Proposed Timescale: 02/06/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose was not fully compliant with the regulations with an improvement required in the details of the services to be provided, arrangements for admissions and reviews of the personal plans.

Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The statement of purpose has been updated as recommended and is ready for review with Operations Manager on 11/06/15.

Proposed Timescale: 11/06/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Managements systems did not provide effective implementation of care practices and monitoring of care.

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:

- 1) The PIC for the 2 other centres that are some distance away is being reviewed with these centres and it is planned that a decision on this will be finalised by the end of June'15. Notifications to HIQA will follow as necessary
- 2) An interim plan has been implemented to improve systems to provide effective implementation of care practises and monitoring of care.

3 CNM2's will work 3 x 12 hours days per week. This will cover 7 days in conjunction with the shifts worked by the 2 CNM1's who work frontline in the houses

Each of the CNM2's will be allocated a house and will be the identifiable manager for that house and be responsible for follow up on issues relating to that house and the service users living in the house.

The interim plan allows the CNM2's to have more effective supervision of the care provided in each house including: Audits of practice including medications, care planning, documentation, complaints, safeguarding plans and implementation of other local procedures.

The most senior CNM2 will deputise as Person in Charge in Director of Nursing's absence. This will be reviewed on recruitment of Assistant Director of Nursing.

1. 30/06/15
2. Interim plan in situ since 25/05/15.

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

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

Roles and functions of managers were not satisfactory to ensure safe care.

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:

- 1) An interim plan has been implemented on 25/05/15 ie 3 CNM2's will work 3 x 12 hours days per week. This will cover 7 days in conjunction with the shifts worked by the 2 CNM1's who work frontline in the houses. Each of the CNM2's will be allocated a house and will be the identifiable manager to ensure safe care.
- 2) HR Dept. consulted with regard to reviewing roles and functions and the Quality Improvement team (HSE) contacted for input. The interim plan will be amended following the review to ensure safe care.

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

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

No full report was available which detailed the quality and safety of care and included the view of residents and relatives.

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:

- 1) An unannounced visit to the Centre had taken place on 05/03/15 and is available.
- 2) A quality review of the service is scheduled for 16/06/15

Proposed Timescale: 05/03/2015

Theme: Leadership, Governance and Management

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

There were no systems yet in operation to provide support and supervision to staff.

Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

- 1) A draft supervision policy is now available for sign off and Managers have been allocated staff for supervision commencing 15/06/15
1. Structured staff supervision to commence 15/06/15.

Proposed Timescale: 15/06/2015

Theme: Leadership, Governance and Management

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

One of the houses was not satisfactorily managed and staffed.

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:

1) An interim plan to manage the houses was implemented on 25/05/15 ie 3 CNM2's will work 3 x 12 hours days per week. This will cover 7 days in conjunction with the shifts worked by the 2 CNM1's who work frontline in the houses. Each of the CNM2's will be allocated a house and will be the identifiable manager.

2) Additional staff have been requested and approved temporarily to provide 1 to 1 support for 2 residents to support activation for defined periods during the week.

3) A Business Case is being prepared for Senior Management for consideration regarding ongoing management structure and staffing, the latter based on recommendations of the Consultant Psychologist

A review of properties to rent nearer the main house has been undertaken but possibilities at present are limited and no decision can be taken until 3) is complete.

Proposed Timescale: 30/06/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

There was insufficient deployment of staff and inadequate maintenance of the premises.

Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

1) An interim plan has been implemented 25/05/15 ie 3 CNM2's will work 3 x 12 hours days per week. This will cover 7 days in conjunction with the shifts worked by the 2 CNM1's who work frontline in the houses. Each of the CNM2's will be allocated a house and will be the identifiable manager of the premises.

- 2) A business case for the ongoing provision of improved local governance and staffing resources will be finalised when recommendations of the Consultant psychologist are available
- 3) Resources have been specifically allocated to progress maintenance issues .The majority of maintenance issues outstanding at time of inspection have been addressed. Some outstanding issues -awaiting delivery of parts eg shower doors.
- 4) The requirement for ongoing available funding to prioritise maintenance issues has been highlighted through the line management structure for prioritisation.
1. 25/05/15 2. 30/06/15 pending recommendations being available. 3. Specific issues outstanding at time of inspection prioritised and all to be finalised by 12/06/15 (assuming delivery of parts required). 4. Done.

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

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

The number and skill mix of staff were not sufficient or satisfactory deployed to meet the needs of the residents safely.

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:

- 1) An interim plan has been implemented on 25/05/15 to improve management of the houses as outlined above. Additional staff have been requested and approved temporarily to provide 1 to 1 support for 2 residents to support activation for defined periods during the week.
- 2) Every effort will be made by management to ensure staffing levels are in situ by using agency when required. As nursing staff may not always be available when required decisions have to be made regarding where the requirement for a nurse is highest.
- 3) A business case is being prepared for Senior Management for consideration regarding ongoing management structure and staffing, the latter based on recommendations of the Consultant Psychologist. In addition the three residences have a total allocation of a .5 WTE Domestic staff which is currently vacant and with the National Recruitment Service for filling. The need for catering staff will be reviewed as part of the overall review of resources required.

A review of properties to rent nearer the main house has been undertaken but possibilities at present are limited and no decision can be taken until we have completed the business case.

Proposed Timescale: 1.In situ. 2. Ongoing. 3. 30/06/15.

Proposed Timescale: 30/06/2015

Theme: Responsive Workforce

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

Not all documents required by the Regulations in terms of staff files were present.

Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

1. All matters raised during the inspection of staff files have been addressed.
2. New file management system has commenced 11/05/15.
Completed and will be ongoing.

Proposed Timescale:

Theme: Responsive Workforce

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

Staff did not have access to mandatory training.

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:

1. Fire Training has been completed for 14 of the 17 staff and will be completed for the remaining three staff on 04/06/15.
 2. Training in abuse has been arranged for the staff who require same commencing the 15th June 2015. A local procedure for the implementation of the HSE Policy for Safeguarding of Vulnerable Adults has been developed.
 3. Certificates for MAPA Training have been put on each staff members training file.
 4. Certificates for Fire Training are not available as they are not provided but a copy of the attendance sheet for each staff member have and will be put on each staff members training file as training is undertaken.
 3. An excel sheet of training is available and updated and will be reviewed at LMT meetings on a monthly basis.
1. 04/06/15 2. Commencing 15th June 3. Complete 4. 04/06/15 and monthly.

Proposed Timescale: 15/06/2015