Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Muiríosa Foundation
Centre ID:	OSV-0003958
Centre county:	Westmeath
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Muiríosa Foundation
Provider Nominee:	Josephine Glackin
Lead inspector:	Jillian Connolly
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
06 October 2015 10:30	06 October 2015 18:30
07 October 2015 10:30	07 October 2015 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 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

The designated centre consists of three community houses located in Co. Westmeath. The designated centre is operated by the Muiriosa Foundation. This inspection was conducted following an application by the provider to register the designated centre under the Health Act 2007. The application was to provide services for fourteen residents.

This was the second inspection conducted in two of the community houses. At the time of the initial inspection, the two community houses were part of another designated centre. However following on from this, the service was re configured which resulted in the two community houses being joined with the third community

house to create this designated centre. As part of this inspection, the inspector followed up on the matters arising from the previous inspection in two of the houses and found that in the main, actions had been taken to address the failings previously identified. There was one twin room identified as not being suitable to meet the needs of residents. Whilst action had been taken to reduce the occupancy of the room, it had not been achieved as of the day of inspection. Therefore the failing is repeated at the end of the report.

The inspection was facilitated by the person in charge. Feedback was provided to the person in charge, area manager and provider nominee at the close of inspection. The inspector met with residents and staff during the course of the two days. The inspector also observed practice and reviewed documentation. In the main, residents reported satisfaction with the service provided. However the inspector found that the quality of service provision varied depending on the supports required by residents.

Compliance was identified in five of the eighteen outcomes inspected. Moderate non - compliance was identified in eight of the outcomes. Major non compliance was identified in the remaining five outcomes.The core issues pertained to the resources in one community house which impacted on the provision of service to residents residing there. Improvements were also required in the systems in place for the management of fire and the monies paid by residents. An immediate action was issued in respect of regulation 15 (1) on the day of inspection.

There were twenty three failings of regulation identified on this inspection.

The action plan at the end of this report identifies the failings and the actions the provider/person in charge is required to take 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.

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):
No actions were required from the previous inspection.

Findings:
The designated centre had policies and procedures in place regarding the management of complaints. The person in charge was the nominated person for the receipt of complaints in the designated centre. The information was displayed in an accessible format in the designated centre. There was a record of complaints maintained by the person in charge however it was not located in the designated centre as required by Schedule 4 of the regulations. The inspector found inconsistent practice in respect of the management of complaints. For example, staff demonstrated that they were knowledgeable of the procedure to be followed. Areas of dissatisfaction expressed by residents were recorded inclusive of the action taken. Residents stated that they were comfortable highlighting issues to staff or to the person in charge.

However there was one complaint recorded in the register. The inspector reviewed the complaint and found that whilst the complaint was recorded, the information did not provide adequate information of the investigation into the complaint and action taken on foot of the complaint as required by Regulation 34 (2) (f).

During the inspection, the inspector observed the staff to engage with residents in a respectful and dignified manner. Residents who had their own bedroom were facilitated to undertake personal activities in private. However there was one twin room in the designated centre which the inspector deemed was not fit for purpose. This had been a finding on the previous inspection and plans were in place to reduce the occupancy of the room. This had been achieved following consultation with the residents residing in the room and their family. Weekly meetings were standard practice within the designated centre and demonstrated a forum for engagement with residents regarding the operation of the designated centre.

Of a sample of individual records reviewed, the inspector confirmed that a record of residents' personal possessions were maintained the designated centre. A review of same evidenced that residents had purchased items of furniture which were utilised in communal spaces of the designated centre. This is outside the policies and procedures of the designated centre and the written agreement between the resident and the provider. The inspector requested a review of all residents' personal belongings at the close of inspection. Management committed to same and stated that affected residents would be refunded immediately.

The designated centre provides services for individuals with an intellectual disability. There were significant variances in the supports required for individuals to engage in activities. The inspector found that this resulted in inconsistent practice regarding the opportunities residents had to engage with activities in line with their interests and capabilities. For example, the inspector observed some residents to be active participants in the local community by attending activities which they had chosen and enjoyed. In other instances, residents access to the local community was minimal. For example, one resident had not left the designated centre in a ten day period as the staffing levels did not facilitate same. Whilst efforts had been made to develop participation in activities in the home, the inspector observed one resident to not be engaged in any form of activity for a two hour period bar being supported with personal hygiene.

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:
The designated centre had a policy in place to guide the practice for communication with residents which was implemented in August 2014. The Inspector observed staff communicating with residents and found that they were aware of the individual methods of communication for each resident. There was evidence that external supports had also been sought from the relevant Allied Health Professional if required. The individual communication requirements for residents were also documented in their personal plans.

The designated centre had a television and radio in place for residents.

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:
There was a policy in place regarding the appropriate practice to support residents to receive visitors. There were areas in the designated centre in which residents could meet visitors in private if required. There was a record of communication with family members regarding the well being of residents.

For residents, whose family were not in a position to see them on a regular basis, efforts had been made to develop links with volunteers.

Residents involvement in the local community did vary, as stated in Outcome 1, depending on the individual supports residents required. This resulted in the majority of interaction being between residents in the home and staff as opposed to community links.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
There was a policy in place on admissions, including transfers, discharge and temporary absence of residents in the centre. A standard operating procedure had also been developed to guide the practice specific to the designated centre. One resident was in the process of being discharged from the designated centre. The inspector reviewed

the actions which had been taken to date to support the resident with the discharge and found that it was appropriate and in compliance with regulation.

Each resident had a written agreement with the registered provider which stated the terms in which the resident will reside in the designated centre. The agreement also stated the fees to be paid inclusive of additional charges. The inspector reviewed the financial records of residents and found that there were discrepancies in the payments of residents for a six week period between February and March 2015 to that which was stated in the written agreement. The inspector requested that the provider review all payments made by all residents in that time period during the closing meeting. Management agreed that this would occur and any overpayment would be refunded immediately. As stated in Outcome 1, residents had also purchased communal furniture for the centre.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
The inspector reviewed a sample of personal plans of residents. The practice of the designated centre was that following a comprehensive assessment of the health and social care needs of residents, a plan would be developed to meet any identified need. There were also risk management plans if the need identified presented a risk to the well being of the resident or others.

The personal plans consisted of both long and short term goals. The inspector found inconsistencies in the effectiveness of the plans in place. For example, some residents were actively involved in their personal plans and demonstrated to inspectors the progress that they had attained towards achieving their goals. Other residents had clearly demonstrated a wish to not achieve their goal however there was an absence of evidence to demonstrate that alternative goals had been discussed. In other instances residents did not have an active personal plan in place, with the last meeting to discuss this being two years prior to the inspection. Efforts had been made to present the

personal plans of residents in an accessible format. There was evidence that some relatives had been involved in the goal planning process however this was not consistent. Improvements were also required to the plans in place to meet the healthcare needs of residents which is evidenced in Outcome 11.

The organisation employs a variety of Allied Health Professionals. There was evidence that they were involved in the supports required to residents. Improvements were required in the consistency of referrals, particularly in relation to healthcare needs.

As stated previously, a resident was involved in the process of discharge from the designated centre. The resident showed the inspector their transition plan which was in an accessible format and communicated that they were actively involved in the process.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The designated centre consists of three houses, one of which was purpose built. Two of the houses were bungalows and one house was a two story house. All of the houses were clean and suitably decorated as of the day of inspection. Residents' bedrooms were personalised and communal spaces were reflective of a homely environment. There was sufficient heating and lighting in the designated centre on the day of inspection. Each house had a kitchen/dining area and separate sitting room. There was also a separate utility room in each of the houses. There were sufficient bathrooms in each house to meet the needs of the residents residing there. As stated previously there was one twin room in the designated centre which the inspector deemed was not fit for purpose as it did not afford sufficient private space for residents. There was also a bedroom of one resident which posed a risk from a fire management perspective and is evidenced in Outcome 7.

Each of the houses had external grounds which were well maintained. The houses were adapted based on the residents residing there. There was a handrail required at the back door of one of the houses.

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

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The organisation had policies and procedures relating to health and safety. There was an up to date safety statement in place. There was also a risk management policy which specified the particulars of Regulation 26. There were assessments of risks completed in the designated centre which included environmental, operational and clinical risks. The assessment of risks pertained to hazards which were relevant both to all residents, staff and visitors and to individuals. The inspector reviewed a sample of risk assessments and found that improvements were required to ensure that they robustly assessed the actual risk present as in some instances they were generic and not reflective of the practice of the designated centre. For example, the risk related to individuals residing with other residents who displayed aggressive or assaultive behaviour was assessed. The assessment however did not identify that there was a clear pattern as regards to the individuals primarily impacted. In one of the community houses residents required the support of two staff for personal care. There were regularly only two staff in the designated centre. This resulted in residents being unsupervised for periods of time. Staff confirmed this practice to the inspector. The risk was increased due to the clinical needs of residents. This risk had not been identified and appropriate action had not been taken to reduce the risk.

The designated centre had policies and procedures in place regarding the management of infection. The centre was visibly clean and there was a colour coded system in place for cleaning and the preparation of foods. Improvements were required in the laundry room in one of the community houses as there was an absence of facilities to ensure appropriate hand hygiene practices were in place.

The inspector reviewed the practices for the prevention, detection and management of fire and found that improvements were required. The designated centre had obtained the services of an external provider to ensure that equipment was checked and serviced at regular intervals. There were also internal procedures in place to ensure that fire exits were operational and clear. However the inspector was not assured of the accuracy of the internal procedures as on the day of inspection, one door was challenging to open and there was also furniture obstructing a clear pathway to the fire exit. This had not

been identified by staff. There was an absence of directional signage from the kitchen of one designated centre to a final fire exit. There was also a final fire exit which had steps; however there was no handrail which the inspector determined posed a risk. Fire doors had been installed in the centre, however the self closers were not functioning efficiently as the door was not closing completely. There was also a gap of approximately one inch between the door and the floor which invalidated the purpose of the door. The fire assembly point in one house was in an inaccessible location considering the needs of residents. There was one bedroom in the designated centre which is considered an inner room. The only exit in the event of an emergency is directly into a utility room. The inspector determined that this is not appropriate.

Each of the residents had a personal evacuation plan in place which aimed to instruct on the specific supports that residents required to effectively evacuate to a safe location. The inspector reviewed a sample and determined a review was required to ensure that they were reflective of the actual needs of residents. For example, in one community house each resident was documented as requiring no assistance to evacuate the building. However fire drills evidenced that one of the residents require verbal prompts. Some of the residents were able to demonstrate to the inspector the action to be taken in the event of a fire. In one of the community houses, the evidence did not support that in the event of a fire, the staffing levels at night could support the safe evacuation of residents. As a result the inspector issued an immediate action in respect of staffing levels to the registered provider. The provider responded by increasing the staffing levels at night immediately.

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:
The designated centre had policies and procedures in place for the protection of vulnerable adults. Staff were knowledgeable of the actions to be taken in the event of an allegation or suspicion of abuse. Staff had also received the appropriate training. Residents stated that they felt safe.

There is a policy in place for the provision of behavioural support to residents. There is also a policy in place regarding restrictive practice. There was a record of all restrictive practices maintained in the designated centre which were in the main safeguards such as bedrails or lap straps on wheelchairs. Efforts had been made to support residents who experience behaviours that challenge. Improvements were required to ensure that the assessments, plans and subsequent reviews identified the underlying causes of behaviour. For example, there had been assessments completed and plans created inclusive of strategies. Staff were recording all adverse events which occurred from residents exhibiting aggressive or assaultive behaviour. Evidence did not support that the reviews of the plan included the factors which could have contributed to the incident or the effectiveness of the strategies. Staff had received training in supporting residents who experience behaviours that challenge.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
The inspector confirmed that a record of accidents and incidents was maintained in the designated centre. All incidents which were required to be notified to the Chief Inspector were submitted within the appropriate time frames. The person in charge was knowledgeable of their statutory responsibility to do so.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
There was a policy in place regarding residents' access to education, training and development. The implementation of this policy within the designated centre was inconsistent. In some instances residents were supported to engage in training programmes. For other residents, the evidence did not support that the potential opportunities were assessed. As stated previously engagement in activities were also significantly varied depending on the supports required by individuals, staffing levels and the collective needs of the all of the residents residing in the house.

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

Findings:
The inspector determined that significant improvement was required to ensure that the healthcare needs of residents were being consistently met. There was evidence that residents were supported to access their general practitioner if a need arose or were supported to attend an acute setting. However improvements were required to ensure that residents' health needs were appropriately assessed and met by the care provided in the centre.

Through the assessment process, healthcare needs of residents were identified. However the plans of care in place to guide staff on the supports residents required to meet that healthcare need were insufficient, both for chronic and acute needs. For example, there was evidence of one resident being admitted to an acute setting due to an illness. However the plan of care in respect of this need, did not reference the admission to hospital or the specific proactive strategies required to prevent a readmission. Whilst in other instances there were comprehensive plans of care in place which clearly identified the strategies required to support a resident. The evidence did not support that following discharge from hospital all appropriate measures were taken to monitor the well being of residents.

As stated in Outcome 5, improvements were required in the consistent access to Allied Health Professionals. For example, there was one resident who was documented as requiring support however there was no evidence of referral of same.

There was a policy in place to guide practice on the appropriate nutritional intake of residents. The inspector reviewed the practice regarding this and found that the practice was not consistently reflective of the policy. For example, if a resident had a need identified the procedure is for their weight to be monitored regularly. This was not occurring due to the weighing scales being out of commission for a disproportionate period of time. There was also evidence in which residents were supported to engage in a healthy eating in order to reduce their weight. However the evidence did not support that the plan in place was effective. Staff stated that this was due to choice of the resident. However the inspector observed mealtime and found that whilst it was a pleasant and social event, the portions size were not in line with evidence best practice. There was also an absence of records maintained of the food provided to residents to demonstrate that it was nutritionally balanced and inline with the recommendations of Allied Health professionals.

Judgment:
Non Compliant - Major

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

Findings:
The designated centre had policies and procedures in place regarding the ordering, prescribing, storing and administration of medication to residents. The inspector reviewed a sample of prescription and administration records of residents and found that they contained all of the necessary information as required by regulation. Medication was stored in a secure location and there were appropriate practices in place for the receipt and return of medication to the pharmacy. Staff had received training in the administration of medication.

There were guidelines in place for the administration of medication as required for residents. There was also a rationale maintained for when each time medication as required was administered such as in the event of seizure activity or in the event of pain relief being required.

The inspector reviewed the incident form regarding a medication error. Whilst the process involved had followed the policy of the organisation, the inspector found that the review omitted one core deficit in practice which had fundamentally resulted in the error.

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

Findings:
As part of the application to register the registered provider was required to submit a copy of the Statement of Purpose of the designated centre. The inspector reviewed the document and found that it contained all of the necessary information as required by Schedule 1 of the regulations.

Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
There is a clear management structure in place in the designated centre. The regional director is provider nominee who reports directly to the Chief Executive Officer of the organisation. The regional director is supported by the area manager who has the responsibility for seven designated centres. The person in charge reports to the area manager. Residents and staff were familiar with the person in charge. The person in charge has the qualifications to manage the designated centre.

The person in charge is required to complete monthly audits which include complaints, finances and medication. From this the person in charge is required to report the findings to the area director who in turn reports to the provider nominee on a monthly basis. However considering the deficits identified in practice in respect of the personal plans and support provided to residents in respect of their healthcare needs, the inspector determined that improvements were required to ensure that audits were conducted in this area. There were also improvements required to ensure that reviews of practice such as positive behaviour support and medication errors were reflective of all contributing factors.

There was also an annual review of the quality and safety of care completed by the provider nominee utilising the framework of the National Standards published by the Authority. A deficit identified in this review was that as there were no residents at home when the review was completed, their views were not incorporated at the time.

Judgment:
Non Compliant - Moderate

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:
The person in charge had not been absent from the designated centre for more than 28 days since they commenced their post. Therefore it was not necessary to notify the Chief Inspector as required by Regulation 32. However the registered provider had identified a person participating in the management to deputise in the event of this occurring.

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:
As stated previously residents' opportunity to engage in activities in line with their interests and capabilities significantly varied based on their individual needs and the collective needs of the residents residing in the same house. In two of the community houses, residents were active participants in the local community however in other instances residents left their home infrequently. There was also evidence that residents with complex clinical needs were unsupervised for periods of time due to the needs of other residents in their home. The inspector reviewed a sample of rosters and met with staff and determined that this was due to insufficient staffing levels in one of the community houses. Therefore the designated centre was not sufficiently resourced.

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):
No actions were required from the previous inspection.

Findings:
There was a planned and actual roster maintained in the designated centre. The staffing on the day of inspection was reflective of this and in line with the Statement of Purpose of the designated centre. An immediate action was issued on the day of the inspection to the registered provider in respect of Regulation 15 (1) as the cumulative evidence demonstrated that the staffing levels in one of the houses was insufficient to meet the needs of the residents. The provider responded by increasing the staffing levels immediately.

As stated in Outcome 11, evidence did not support that the appropriate care was provided to residents following discharge from hospital.

The inspector reviewed a sample of training records and found that staff had received the appropriate mandatory training inclusive of manual handling training. Additional training had also been provided such as food hygiene, hand hygiene and diabetes.

There was evidence that staff supervision occurred at regular intervals.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Staff records are maintained in the central offices of the designated centre. As a result the inspector completed an additional fieldwork day to inspect the records as required Schedule 2. Of the sample of files reviewed in respect of staff employed in this designated centre, the inspector found the files to contain the necessary information.

The records as required by Schedule 3 were also maintained within the designated centre. However as evidenced throughout this report, improvements were required to ensure that they were comprehensive and provided sufficient information of the supports residents require.

Improvements were required in the records as required by Schedule 4, as whilst there was a record of complaints, it was not maintained in the designated centre. Improvements were also required to ensure that records were maintained of the food provided to residents in sufficient detail to determine if the diet is satisfactory and in line with the recommendations of Allied Health Professionals.

The inspector confirmed the polices as required by Schedule 5 were maintained in the designated centre.

The inspector confirmed that the designated centre is adequately insured against accidents or injury to residents, staff and visitors.

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:

Jillian Connolly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Muiríosa Foundation
Centre ID:	OSV-0003958
Date of Inspection:	06 October 2015
Date of response:	23 December 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:
Some residents did not have adequate access to opportunities for recreation.

1. Action Required:
Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

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

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

• Recruitment to a 30 hour post has commenced to supplement the staff team during the day in one location where community opportunities were limited due to staffing levels.

• This additional post will allow individuals to pursue options of particular interest to them.

Proposed Timescale: 04/01/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The information maintained did not provide adequate information of the investigation into the complaint and action taken on foot of the complaint.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 20/10/2015

• Details of complaints are held within the relevant location – within the Complaints folder. However, the background information regarding the handling of the complaint has been transferred from the administration office to the relevant location.

Proposed Timescale: 20/10/2015

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

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents access to links with the wider community varied depending on the supports they required.

3. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

o Recruitment to a 30 hour post has commenced to supplement the staff team during the day in one location where community opportunities were limited due to staffing levels.

o This additional post will allow individuals to pursue options of particular interest to them.

Proposed Timescale: 04/01/2016

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:
Whilst each resident had a contract of care which stipulated the fees to be charged, monies paid by residents was not inline with same.

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

Please state the actions you have taken or are planning to take:
• The two amendments required to reflect a reduction in the payment of charges by residents due to their individual nutritional needs have been completed.

Proposed Timescale: 11/11/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The social care needs of residents were not being met due to an absence of appropriate staffing.

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

Please state the actions you have taken or are planning to take:
• Recruitment to a 30hr post has commenced to supplement the staff team during the day in one location where community opportunities were limited due to staffing levels.

• This additional post will allow individuals to pursue options of particular interest to them

Proposed Timescale: 04/01/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents' personal plans were kept under regular review.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 30/11/2015

1. The person in charge has undertaken a review of all residents' Personal Plans and relevant new goals have been identified.

2. This has been done in conjunction with the local staff team and relevant key workers.

Actions Planned:

1. This will form part of ongoing supervision between the PIC and support team over the next six months.

2. Clinical care plans are being devised for specific health conditions as a supplementary document to existing care plans.

3. The clinical care plans will be discussed at the local staff team meetings.

Proposed Timescale: 30/01/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents and/or their representative were not consistently involved in the personal plan of residents.

7. 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:
The keyworker in conjunction with the person in charge has responsibility for ensuring that residents and other representatives as appropriate are afforded maximum involvement in the process.

1. The proper use of the Participation and Engagement Plan will be discussed at the next local staff team meeting.

2. Local guidelines devised by the PIC to support the correct use of the Participation and Engagement Plan will be available on site.

3. It will form part of one to one supervision as required for the local staff team.

Proposed Timescale: 30/01/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The twin room did not provide sufficient private space to two residents.

8. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
Substantial work had been undertaken to address the issue of two residents sharing a twin room. The resident in question had a transition plan which reflected the individual's visits to her new home which have been supported by staff.

Actions Planned:

• The twin room in the designated centre will be decommissioned and the Statement of Purpose and Function changed to reflect this change once the individual has moved.

Date For Completion: 14/12/2015.

• The resident will be fully transitioned to her new home by 09/12/2015.

Proposed Timescale: 14/12/2015

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:
Improvements were required to ensure that the control measures in place were reflective of the actual risks in the designated centre.

9. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
Actions Completed: 11/11/2015

• A risk assessment has been completed for the non ambulant individuals who live in the house and who are left unsupervised for short periods of time. The risk assessment has indicated that this practice represents a risk that is negligible for individuals residing within the community houses.

Actions Planned

• A review will be undertaken by the person in charge and the area director. Findings will be discussed with the local staff team to ensure all view points are incorporated. This review will have three strands

1. Incorporating a walk through inspection of the property inside and out.

2. A review pertaining to the support needs of the people living within the location will be undertaken. To ensure that all hazards are identified and appropriate control measures are in place.

3. A review of the existing Risk assessments and control measures

Proposed Timescale: 30/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of appropriate hand hygiene facilities in the designated centre.

10. 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:
Actions Completed: 08/10/2015

A paper hand towel dispenser is now located in the Laundry room.

Proposed Timescale: 08/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the self closers on the day of inspection were not operating effectively.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 19/11/2015

- The relevant self closures on the doors have been adjusted and passed as effective by the fire officer.

Actions Planned

- Section 10 of the fire register daily check form will be amended to include daily checks on Self-Closures. Circulated to all locations. To be completed 18/12/2015.

- The amended Daily check form will be introduced to the staff team at the next staff team meeting.

- When this form has been amended and introduced to the local staff team the PIC will undertake spot checks for a period of time to ensure that the form is being completed correctly and report back accordingly to the local staff team.

Proposed Timescale: 20/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Whilst records demonstrated that checks were completed regularly, the validity of the checks were compromised due to the findings of this inspection.

12. Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
Actions Completed: 08/10/2015

• The person in charge has reviewed all the residents' Fire Evacuation Plans and made amendments as required.

• The control measures required for safe and effective evacuation of all residents have been noted and same has been communicated to the local staff team.

Actions Planned

• Handrail to be fitted at fire exit with steps – completion date 31/01/2016.

• Gaps identified under door as a result of removal of door saddle to be rectified – completed on 31/01/2016.

• Directional signage from kitchen to Exit- signage to be erected – completion date 18/12/2015.

• Revision of Section 10 of Fire Register daily check form will be amended to include daily checks on self closures. Circulated to all locations - completion date 18/12/2015

• They will review with the staff team and the person in charge why the fire issues identified in the report were not highlighted accordingly in the monthly fire safety check form - to be completed at next house meeting.

• A session with the fire officer and the person in charge will undertake a local training session with staff on the correct completion of the daily and monthly check form.

• The person in charge will audit the next three fire check forms to confirm that they have been correctly completed by staff.

• Feedback will be given to staff through the local team meetings or supervision as appropriate.

• The proposal in relation to the fire assembly point is to eliminate two parking spaces and excavated section of the lawn to allow for wheelchair access. Adequate lighting will be erected in this area.

Proposed Timescale: 31/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The exit of one of the bedrooms was directly into a utility room which did not provide adequate means of escape to the resident residing there. The inspector further observed that the pathway to one fire exit was obstructed by furniture.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 08/10/2015

• The coffee table has been removed and the pathway is clear for safe fire evacuation and discussed with staff team. Completed 08/10/2015.

• A discussion involving the operations manager, fire officer and the person in charge took place to discuss the inspector's findings in relation to the resident's bedroom.

• A risk assessment has been completed to ascertain the risk to the resident in terms of their fire safety in the current situation. The risk has been found to be low.

• Following the risk assessment, individual training sessions were organised for the individual with the fire officer and the person in charge to ensure that the individual can safely evacuate the building should the need arise.

• The individual has demonstrated a high capacity of understanding of fire safety and the importance of evacuating immediately on hearing the fire alarm.

Actions Planned:

o The proposal is to erect a door frame with a 30 minute fire door, magnetic catch to be fitted and connected to the Fire Alarm System. Install Emergency lighting and exit sign. This will ensure a protective means of escape for the resident.

Proposed Timescale: 31/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that the number of staff in one designated centre was sufficient to evacuate residents in the event of a fire.

14. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for

evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
Actions Completed: 07/10/2015

• Following the receipt of an immediate action during the inspection, a second night staff was placed on duty in a particular residence.

Actions Completed: 21/10/2015

• Taking cognisance of the increased night staff the Personal Fire Evacuation Plans have been reviewed and amended as required by the person in charge.

Proposed Timescale: 21/10/2015

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:
Evidence did not support that the reviews of the effectiveness of the plan included the factors which could have contributed to the incident or the effectiveness of the strategies.

15. 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:
Actions Planned:

• The behavioural therapist is to review the risk assessments, the proactive and reactive strategies and the effectiveness of same. After which the behaviour therapist and person in charge will ascertain the changes required and communicate same to the relevant staff team through the local team meetings.

• A.B.C. forms will be reviewed by the person in charge and behaviour therapist to ascertain the effectiveness of the pro-active and re-active strategies on a monthly basis.

Proposed Timescale: 20/12/2015

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' access to opportunities for education and employment were inconsistent.

16. 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:
Actions Commenced:

• Recruitment has commenced to supplement the staff team with a 30 hour post during the day in one location where community opportunities were limited due to staffing levels.

Proposed Timescale: 04/01/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that the health care needs of residents were comprehensively assessed and an appropriate plan of care was developed. The evidence did not support that following discharge from hospital all appropriate measures were taken to monitor the well being of residents. Residents were not supported to have their weight recorded at appropriate intervals.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 05/11/2015

• A standard operational procedure has been developed which provides guidance on procedures to follow post hospital discharge in order to adequately monitor the well being of the individual.

• This has been introduced to the local staff teams through the local team meetings by the person in charge.

• The person in charge has reviewed the appropriate health care plans to ensure they are appropriate to support the residents' acute and long term health care needs.

• The weighing scale's has been repaired and residents are weighed as directed by their

Personal Care Plan.

Actions Planned:

• The person in charge will utilise the Health Care template which highlights the specific conditions that the person requires support on and the monitoring required by staff. It also directs staff to the relevant Health Care sections pertinent to that particular condition.

• The person in charge will discuss the Health Care template and its purpose at the next local team meeting.

• Where appropriate proper use of the Health Care template will be discussed at supervision meetings of individual members of the staff team.

• Training will be provided by the Centre of Nurse Education to relevant staff in recognising and responding to deviations in general health and well being of the individual.

Proposed Timescale: 29/02/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in the consistent access to Allied Health Professionals.

18. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
Actions Commenced: 07/11/2015

• All referrals by General Practioner to Allied Health Professionals will be acted upon and recommendations received will be addressed.

• On receipt of recommendations, individual's care plans will be updated accordingly.

• The PIC will undertake a review of the health needs of individuals within the designated centre. This will ensure that individuals are receiving the appropriate supports for specific health issues.

• The PIC will be supported by the area director in this review.

Proposed Timescale: 25/11/2015

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:
Improvements were required to ensure that deficits in practice were identified by management.

19. 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:
Actions Planned:

• The person in charge will utilise the Health Care template which highlights the specific conditions that the person requires support on and the monitoring required by staff. It also directs staff to the relevant Health Care sections pertinent to that particular condition.

• The behavioural therapist is to review the risk assessments, the proactive and reactive strategies and the effectiveness of same. After which the behaviour therapist and person in charge will ascertain the changes required and communicate same to the relevant staff team through the local team meetings.

• A.B.C. forms will be reviewed by the person in charge and behaviour therapist to ascertain the effectiveness of the pro-active and re-active strategies on a monthly basis.

• The person in charge will ensure the ongoing use of the spot check form which will be used to identify any deficits or observations that are required to be addressed by the person in charge or the staff team. The findings of the spot check forms will be fed back to the staff team at the local team meetings.

• A review will be undertaken by the person in charge and the area director. Findings will be discussed with the local staff team to ensure all view points are incorporated. This review will have three strands

1. Incorporating a walk through inspection of the property inside and out.

2. A review pertaining to the support needs of the people living within the location will be undertaken. To ensure that all hazards are identified and appropriate control measures are in place.

3. A review of the existing Risk assessments and control measures.

Proposed Timescale: 30/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The review conducted of quality and safety of care did not incorporate the views of residents.

20. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

• The Annual Review for Quality and Safety for 2015 will incorporate the views of residents within the designated centre.

Proposed Timescale: 27/02/2016

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 resources allocated to one community house to ensure that the individual needs of residents residing together were met.

21. 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:
Actions Planned:

• Recruitment to a 30 hour post has commenced to supplement the staff team during the day in one location where community opportunities were limited due to staffing levels.

• This additional post will allow individuals to pursue options of particular interest to them.

• A review of the support intensity scale assessment by the person in charge for the

residents residing in one community house to be undertaken to ascertain if the resources available in the location are sufficient.

Proposed Timescale: 30/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of residents residing in one community house were assessed as requiring the support of two staff to support them with personal care. Evidence did not support that in the event of a fire residents could be safely evacuated from the designated centre. Residents who are assessed as presenting with complex needs were unsupervised on a regular basis in the designated centre. Therefore an immediate action was issued in respect of this regulation.

22. 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:
• An additional night staff has been put in place to ensure safe night time fire evacuation of individuals from one area within the designated centre.

• The person in charge has reviewed all the residents' Fire Evacuation Plans and made amendments as required.

• The control measures required for safe and effective evacuation of all residents has been noted and same has been communicated to the local staff team.

• A risk assessment has been completed for the non ambulant individuals who live in the house and who are left unsupervised for short periods of time. The risk assessment completed has indicated that this practice presents a risk that is negligible for the individual.

• A review of the support intensity scale assessment by the person in charge for the residents residing in one community house to be undertaken to ascertain if the resources available in the location are sufficient.

Proposed Timescale: 02/12/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Evidence did not support that the appropriate clinical actions were taken post a residents discharge from hospital.

23. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
Actions Completed: 05/11/2015

• A standard operational procedure has been developed which provides guidance on procedures to follow post hospital discharge in order to adequately monitor the well being of the individual.

• This has been introduced to the local staff teams through the local team meetings by the person in charge.

Actions Planned:
• A review of the support intensity scale assessment by the person in charge for the residents residing in one community house to be undertaken to ascertain if the resources available in the location are sufficient.

• The person in charge will utilise the Health Care template which highlights the specific conditions that the person requires support on and the monitoring required by staff. It also directs staff to the relevant Health Care sections pertinent to that particular condition.

• The person in charge will discuss the Health Care template and its purpose at the next local team meeting.

• Where appropriate proper use of the Health Care template will be discussed at supervision meetings of individual members of the staff team.

• Clinical care plans are being devised for specific health conditions as a supplementary document to their existing care plans

• The clinical care plans will be discussed at the local staff team meetings.

Proposed Timescale: 30/01/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

Improvements were required to ensure that Schedule 3 records were comprehensive and provided sufficient information of the supports residents require.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 12/12/2015

• The person in charge has undertaken a review of all residents' Personal Plans and relevant new goals have been identified.

• This has been done in conjunction with the local staff team and relevant key workers.

Actions Planned:

• This will form part of ongoing supervision between the PIC and support team over the next six months.

• Clinical care plans are being devised for specific health conditions as a supplementary document to their existing care plans.

• The clinical care plans will be discussed at the local staff team meetings

Proposed Timescale: 30/01/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in the records as required by Schedule 4, as whilst there was a record of complaints, it was not maintained in the designated centre.
Improvements were also required to ensure that records were maintained of the food provided to residents in sufficient detail to determine if the diet is satisfactory and in line with the recommendations of Allied Health Professionals.

25. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
Actions Completed: 20/10/2015

• Details of complaints are held within the relevant location – within the Complaints

folder. However, the background information regarding the handling of the complaint has been transferred from the administration office to the relevant location.

• Menu plans have been adapted to incorporate nutritional value.

Actions planned

• The person in charge will monitor the menu plan to ensure all relevant detail is included.

• Progress notes will be utilised to ensure that they appropriately reflect the dietary intake for the individual for that day.

Proposed Timescale: 20/10/2015