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 Health Service Executive
Centre ID:	OSV-0003999
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Deborah Harrington
Lead inspector:	Kieran Murphy
Support inspector(s):	Geraldine Ryan (day 3 only);Louisa Power (day 1 & 2);Michael Keating(day 1 &2);Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	30
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
25 May 2016 09:30	25 May 2016 20:00
26 May 2016 09:00	26 May 2016 19:00
20 June 2016 09:00	20 June 2016 18:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

On 6 November 2015, HIQA applied to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities which were managed by the Health Services Executive (HSE) all located on the grounds of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

This report relates to a follow-up inspection carried out to verify if progress had been made since the commencement of the court order granted in November 2015. During the course of the inspection significant non-compliance with the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (the regulations) were identified and three immediate actions were issued by inspectors:

• It had not been demonstrated that one resident had been provided with adequate food and nutrition for a period in excess of 18 hours. This was found to be failing to comply with regulation 18(4).

• A healthcare support plan was not being followed in relation to an assessed

healthcare need for adequate food and nutrition. In addition, guidelines for preventing pressure ulcers and the elimination of risk from pressure areas were not being followed. This was found to be failing to comply with regulation 6(1).
• Tt was not demonstrated that fire evacuation drills considered all likely scenarios and conditions, in particular night time conditions and actual staff arrangements in place. This was found to be failing to comply with regulation 28(3)(d).

In response the HSE, as the service provider had put appropriate measures in place to address the deficiencies identified in the immediate action plans. However, the HSE acknowledged that the governance and management arrangements as found on inspection were not satisfactory.

A new person in charge for this centre had been appointed and had started as a Clinical Nurse Manager III (CNM III) in February 2016. However, inspectors were informed by the representative of the service provider on the third day of the inspection that the person in charge intended to resign her position.

Description of the service
The service provided a range of day and residential services to adults with an intellectual disability. The centre was based in a campus style environment with other designated centres on site in Youghal. This centre provided a home to 30 residents in three different "units". Some or many of the residents had complex healthcare needs and a high level of support needs.

The conditions of registration of this centre outlined that the HSE, as the service provider, "will close the designated centre by no later than 31 March 2017 and uses best endeavours to move all residents from the designated centre to alternative appropriate placements by October 2016".

Since the last inspection a number of residents had moved from the centre and were now living in community based settings. In March 2016 the HSE had undertaken an action plan to move the remaining residents from this centre which was a congregated setting to a community based model of service. Elements of the action plan were behind schedule and in particular the assessment of each resident's individual needs.

How we gather our evidence
Since the last inspection residents and their representatives invited HIQA to a service user forum meeting which took place in February 2016. At that meeting the Deputy Chief Inspector explained to residents what the regulations were and how HIQA was regulating service providers and not residents themselves. Residents said that they were unhappy with a number of aspects of how the inspections were being done. These concerns helped HIQA to inform our approach to this inspection, including not starting so early in the morning.

There was an interval of three weeks between day two and day three of this inspection to afford the service provider an opportunity to put measures in place to address the deficiencies identified on the first two days of the inspection. Between the second and third day of the inspection the person in charge had based herself in

one of the units to review the healthcare assessments and plans for residents. She was supported by the person in charge from another designated centre. In the healthcare plans seen by inspectors in this unit on the third day there was evidence that residents' healthcare needs were being assessed appropriately and care plans implemented. However, in the other two units there was evidence that some care plans were not being implemented as directed.

The inspectors met with residents living in the centre and met with staff and the management team. Inspectors also observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures. Inspectors also spoke with staff. Some good practice was observed by inspectors. For example, during the first day of the inspection one resident was observed to be engaging in behaviour that required support from staff. The inspector observed staff responding in an appropriate manner and the behaviour support specialist supported the resident as set out in the support plan for over 90 minutes.

Overall judgment of our findings
There was some evidence of good practice. For example, residents in the centre received a community epilepsy outreach service, coordinated through the neurology and epilepsy department in Cork University Hospital. The epilepsy outreach service was established in 2014 to provide high-quality specialist epilepsy care to people with intellectual disabilities living in residential care.

Each resident had access to a general practitioner (GP). There was evidence of good access to specialist care in psychiatry, with a consultant psychiatrist available to residents as required. Residents also received good support from the occupational therapist, speech and language therapist and physiotherapist. A dietician had also recently been appointed.

However, of the nine outcomes inspected eight were at the level of major non-compliance:

Outcome 5: Social Care needs
For residents still living in the centre there was evidence of the inappropriateness of their current living arrangements.

A comprehensive assessment of each resident's healthcare needs was not always available. In addition, one resident had recently returned from hospital with recommendations in place from a consultant specialist regarding the management of his care. There was no evidence that these recommendations had been reviewed or implemented by the end of the inspection.

In relation to the assessment of residents' needs one resident's healthcare record had a care plan relating to dementia. However, there was no definitive diagnosis of dementia recorded in this resident's healthcare file. In addition, there was no evidence of input from specialists in dementia to guide appropriate care, therapies and activities to promote quality of life and well being for this resident.

Outcome 7: Health and safety and risk management
Significant improvement was required in terms of fire safety arrangements. The process for risk assessment also required improvement.

Outcome 8: Safeguarding and safety
Safeguarding plans following an incident were not being implemented to protect residents.

Outcome 9: Notifications
It was a requirement that all serious adverse incidents were reported to the Chief Inspector within three working days of the incident. However, this requirement was not being complied with.

Outcome 10: General Welfare and Development
During the inspection residents were observed spending long periods of time not engaged in any meaningful activities throughout their day.

Outcome 11: Healthcare
During the course of the inspection significant non-compliance with the requirements of the regulations was identified in relation to supporting residents to achieve and enjoy best possible health. In particular care was not always provided to ensure residents' assessed healthcare needs were being met. In addition, guidelines and care plans to support residents at mealtimes were not being followed.

Outcome 12: Medication management
Unsafe medicines administration practices were observed.

Outcome 14: Governance
Since the last inspection there had been a change to the governance structures of the centre. The acting of director of nursing had overall responsibility for the management of three designated centres managed by the HSE on the campus and another designated centre in the community. The person in charge of each of the four designated centres reported to the acting director of nursing.

The management systems as found on inspection did not provide for effective monitoring of the service provided to residents. The HSE was required to submit to HIQA a copy of their own analysis of the safety and quality of care and support provided in the centre. However, these reports did not adequately review the safety and quality of care and support being provided in the centre.

In addition to the items mentioned in this summary the Action Plan at the end of the report identifies other areas where improvement was required.

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

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
The designated centre did not meet the assessed needs of all residents.

The conditions of registration of this centre outlined that the HSE, as the service provider "will close the designated centre by no later than 31 March 2017 and use best endeavours to move all residents from the designated centre to alternative appropriate placements by October 2016". The HSE, as service provider, had a plan to support residents as they transitioned from the current centre in its congregated setting to a community based model of care. Since the last inspection a number of residents had moved from the centre and were now living in community based settings.

In March 2016 the HSE had undertaken an action plan to move the remaining residents from this centre, which was a congregated setting, to a community based model of service. This action plan outlined that "22-26 residents can be relocated to community based living which require the purchase of between 6 and 8 houses in the community". As part of the action plan the service provider had committed to supporting a family forum facilitated by Inclusion Ireland to allow an opportunity for family members to become familiar with the decongregation plan.

The service provider acknowledged that elements of the action plan were behind schedule. One significant project detail was the assessment of each individual resident's needs. This was to have been completed by the end of May 2016. The action plan outlined that the housing needs of each resident could not be determined until these assessments of need were completed. The service provider outlined that these assessments of need had started on 7 June 2016 with a completion date of July 2016. A

meeting was held with families on Sunday 29 May 2016 to brief families on the assessment process. The representative of the HSE outlined that assessments had input from a multidisciplinary team and were conducted with input from the resident, a family member and staff. The service provider outlined that a deposit had been put on one house and the HSE were actively involved in the purchase of other suitable properties. The service provider was providing training to staff to lead this process of decongregation.

For residents still living in the centre there was evidence of the inappropriateness of their current living arrangements. For example one resident's safeguarding adult protection plan outlined that his "current accommodation was not suitable .....but no alterative accommodation is available". Many of the residents had safeguarding plans to protect them from assault from other residents living in the same unit. In one of the units staff were observed to be attending to one resident to prevent them being hit by another resident.

In one of the units two separate "day spaces" had been created to prevent incidents occurring. One of the "day spaces" was in the main living area and the second was in the bedroom area.

In relation to the assessment of residents' needs one resident's healthcare record had a care plan relating to dementia. However, there was no definitive diagnosis of dementia recorded in this resident's healthcare file. In addition, there was no evidence of input from specialists in dementia to guide appropriate care, therapies and activities to promote quality of life and well being for this resident. The clinical nurse specialist in behavioural support said that there are a number of residents with dementia symptoms but these had not been assessed. In addition, there was no baseline assessment for dementia in place for any resident, which meant the service could not track any deterioration in cognitive functioning.

One resident had recently returned from hospital with recommendations in place from a consultant specialist regarding the management of his care. However, there was no evidence that these recommendations had been reviewed or implemented by the end of the inspection.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Overall, there were a number of measures in place to protect the health and safety of residents and staff. However, significant improvement was required in terms of fire safety arrangements in all four centres.

An immediate action plan was issued to the representative of the provider in relation to fire safety in all four centres. Fire safety drills did not simulate all likely scenarios and situations, such as night-time conditions, times during the day when some residents were alone in their houses or different staffing arrangements. In addition, improvement was required to ensure that documentation arising from fire drills reflected any issues identified during practice fire drills and what action was required to address any identified deficiencies. The representative of the provider responded appropriately to the immediate action plan issued and undertook to ensure that adequate practice fire drills were completed without delay across all four centres.

Between the second and third day of the inspection a series of fire evacuation drills had taken place, including one on 3 June 2016. During this drill it had been identified that a fire door needed to be connected to the alarm system. However, this had not been completed by the third day of the inspection on 20 June 2016. In addition, on the third day of the inspection it was observed that the final exit door in an evacuation route from one of the units did not have a key available which could potentially prevent people from exiting through this door in an emergency.

The process for risk assessment required improvement. For example, on the third day of inspection it was observed that there were no risk assessments available in relation to:
• a bottle of toilet cleaner being accessible to residents in a bathroom
• an open sluice room with potentially infectious materials available
• the storage of dirty linen in a linen trolley outside one resident's bedroom
• an oxygen container being accessible to residents in a walkway in one unit.

Inspectors were provided with a copy of the centre risk register. An organisation risk register was designed to log all the hazards that the organisation was actively managing. There were 36 hazards identified on the register including unexplained absence of residents, self injurious behaviour and accidental injury. While the management of hazards on the register in general was adequate some improvement was required. It was not always recorded who was responsible for managing the hazards on the risk register. For example, for the hazard of "service user drowning from using bath/shower" there was no staff member assigned responsibility to ensure these actions were completed. In addition, there was also no "target date" recorded for completion of the actions; or a review date for the hazards on the risk register.

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:
There was evidence that structures had been put in place minimise the risk of abuse to vulnerable adults and to ensure all allegations of abuse were investigated. However, there was evidence that there was a lack of clarity for staff around the reporting of allegations of abuse. In addition, there was evidence that safeguarding plans were not being followed.

In April 2016 the service introduced a safeguarding review committee to ensure that all centres on the campus worked in collaboration to minimise the risk of abuse to vulnerable adults and to protect vulnerable adults effectively when abuse has occurred or may have occurred. The terms of reference for this committee included "reviewing regularly all incidences at an organisational level; and review operational effectiveness of safeguarding vulnerable adults' policies and procedures". The acting director of nursing was the designated officer for the service and had responsibility for:
• receiving concerns or allegations of abuse regarding vulnerable persons.
• ensuring the appropriate manager is informed and collaboratively ensuring necessary
• actions are identified and implemented.
• ensuring reporting obligations are met.
• other responsibilities, such as conducting preliminary assessments and further
• investigations, may be assigned within a specific service.

The designated officer had received appropriate training regarding her responsibilities in April 2016. Inspectors also spoke with the designated officer. There were now twice weekly meetings of the safeguarding review committee since April 2016.

It was a requirement of the regulations that all serious adverse incidents, including allegations of abuse were reported to the Chief Inspector. There were two significant allegations of abuse submitted to the Chief Inspector since January 2016. Documentation in relation to these incidents were reviewed during the inspection. Both incidents had been "screened" by the designated officer and a safeguarding plan approved.

There was evidence of a lack of clarity for staff around the reporting of allegations of abuse. For example, on one resident's support plan there was a sheet recording

allegations made by the resident. On the records seen by inspectors there were 15 recorded incidents between 26 October 2015 and 16 November 2015 where the resident was noted as alleging that someone "had hit me". Staff did explain that this was part of this resident's behavioural support requirements. However, other than recording when the resident said someone "hit me" there was no evidence of "screening" of these specific allegations of abuse to establish if an abusive act could have occurred and if there were reasonable grounds for concern. Staff did explain to inspectors that if staff saw an incident of a resident hitting another resident this would be reported. From the records provided by the centre, seven staff had not received training in protecting vulnerable adults; and two staff required updated training on protecting vulnerable adults.

Since the last inspection HIQA was in receipt of unsolicited information in relation to an allegation of abuse. HIQA had requested that a formal investigation of this unsolicited information had been undertaken by the provider nominee on behalf of the HSE. HIQA was satisfied that the issues raised had been investigated in accordance with policy on prevention of abuse of residents.

Between the second and third day of inspection a safeguarding issue had arisen and clear guidelines had been issued by the behaviour support service on 3 June 2016 to the effect that an extra staff member at night was to be allocated to one unit to protect one resident from another. However on 6 June 2016 and 19 June 2016 the extra staff had not been provided as directed,

There was a clinical nurse specialist in behavioural support available to residents. Where required residents had positive behavioural support strategies in place which provided clear guidance to staff on antecedents (or causes) to the behaviour, proactive/preventative strategies and if required the reactive or response strategies available to support the resident. During the inspection one resident was observed to be engaging in behaviour that required support from staff. The inspector observed staff responding in an appropriate manner and supported the resident as set out in the support plan for over 90 minutes.

The provider is obliged to notify HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). HIQA was notified in April 2016 that four residents had lapbelts in place as a restraint. Inspectors reviewed documentation relating to the use of the lapbelt restraint for one of these residents. The use of this restraint for this particular resident was in the context of recommendations from an occupational therapist on 27 May 2016 "to encourage mobilising". There was no evidence that the person who was subject to the restrictive procedures was being closely monitored to evaluate the risks to their physical, psychological and emotional wellbeing and to ensure the procedures are minimal in time and in extent.

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:
It was a requirement that all serious injuries were reported to the Chief Inspector within three working days of the incident. However, this requirement was not being complied with.

The term 'serious injury' is not defined in the regulations. However, HIQA issued guidance for registered providers and persons in charge of designated centres on statutory notifications in January 2016. The definition of serious injury in this guidance is "any bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, serious impairment of health or serious loss or impairment of the function of any bodily organ e.g. fracture, burn, sprain/strain, vital organ trauma, a cut or bite resulting in an open wound, concussion etc."

In one resident's healthcare records it was recorded that the resident had been reviewed by a doctor following a fall in April 2016 and it was recorded that there was a "presumed rib fracture". This had not been reported to the Chief Inspector.

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:
At the beginning of the inspection the person in charge outlined that ten residents from the total of 30 residents attended a day service which was based on the campus. The

person in charge said to inspectors that this day service was for two hours in the morning and two in the evening.

However, other residents were not always facilitated to participate in an activities programme that was based on individual need, capacity and preference. During the three days of the inspection some residents were observed spending long periods of time not engaged in any meaningful activities throughout their day. In a review of quality and safety in the centre undertaken on 3 June 2016 by the service provider, it was noted that "activity schedules, particularly in the evening must offer a variation of activities based on residents' wishes and likes".

HIQA was in receipt of unsolicited information in relation to limited activities for particular residents in the centre who had a specific day centre on campus. The HSE as service provider, at the request of HIQA, had undertaken an investigation into this issue and had identified that these residents required care to be provided according to a social model of care. During the inspection it was found that these residents were engaging in more social activities as part of the local community. Staff rosters had also been reviewed to ensure that these residents were consistently supported.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
During the course of the inspection significant non-compliance with the requirements of the regulations was identified in relation to supporting residents to achieve and enjoy best possible health.

In order to address the deficiencies in the care provided to residents two immediate actions were issued by inspectors. On the first day of inspection it was not demonstrated that one resident had been provided with adequate food and nutrition for a period in excess of 18 hours. In addition, a healthcare support plan was not being followed for the same resident in relation to an assessed healthcare need for adequate food and nutrition and the elimination of risk from pressure areas. This was also found on the first day of inspection. In response the HSE, as the service provider, had put appropriate measures in place to address the deficiencies identified in the immediate action plans.

Inspectors reviewed a sample of records that considered residents' healthcare needs. There was evidence that some residents had assessed healthcare needs which had been identified but the care plan was not being followed. For example, on the first day of inspection the healthcare records for one resident had guidelines for preventing pressure ulcers and for providing optimum positioning for one resident which had been recommended by the occupational therapist on 4 April 2016. There was no evidence that these guidelines were being followed. In records seen by inspectors over the first two days of inspection a number of residents had healthcare plans in place which required that fluid intake and output be recorded. There was evidence that the recording of this fluid intake/output was not completed as required. Between the second and third day of the inspection the HSE as service provider had arranged for a review visit on 2 June 2016 to monitor quality and safety on one of the units. This review also found inconsistencies in the recording of fluid intake/output.

Between the second and third day of the inspection the person in charge had based herself in one of the units to review the healthcare assessments and plans for residents. She was supported by the person in charge from another designated centre. In the healthcare plans seen by inspectors in this unit on the third day there was evidence that residents' healthcare needs were being assessed appropriately and care plans implemented. However, in the other two units there was evidence that some care plans were not being implemented as directed. For example, recommendations from a speech and language therapist from 1 June 2016 in relation to one resident's communication needs had not been implemented. It was recorded in the resident's healthcare notes that this was due to "staff shortages". In another example, occupational therapist recommendations in relation to continence care for one resident had not been implemented. It was recorded in the resident's healthcare notes that the plan had been adapted and provided on 14 May but that by 16 June 2016 staff had not obtained the appropriate equipment "to ensure the plan is implemented".

In the sample of resident healthcare records seen by inspectors each resident had access to a general practitioner (GP). There was evidence of good access to specialist care in psychiatry, with a consultant psychiatrist available to residents as required. There was evidence that residents were supported to attend appointments in acute general hospitals and had been referred to consultant specialists if required.

Residents in the centre received a community epilepsy outreach service, coordinated through the neurology and epilepsy department in Cork University Hospital. The epilepsy outreach service was established in 2014 to provide high-quality specialist epilepsy care to people with intellectual disabilities living in residential care. However, on the third day of inspection it was noted that one resident who was reviewed by this outreach service did not have a care plan in place to manage their epilepsy. In another resident's healthcare notes there was a care plan in place to manage epilepsy. However, one staff stated to inspectors that the resident did not have epilepsy.

In one resident's healthcare file it was identified on a document called "the family contact sheet" that the resident was a ward of court. This was the only reference on the healthcare file in relation to this issue and it was since clarified by the administrator for the centre that this resident was not a ward of court. The administrator outlined that other residents were wards of court. In one resident's healthcare file there was no

information in their personal profile or in their hospital passport information that the resident was a ward of court. The lack of information on the healthcare file regarding the residents' wardship had potential implications for consent to treatment by the resident.

A record was maintained of all referrals to and treatment by allied health professionals. There was evidence of residents receiving good support from the occupational therapist, speech and language therapist and physiotherapist. A dietitian had also recently been appointed.

Inspectors saw evidence in resident healthcare plans of reviews by the speech and language therapist with reports detailing safe swallow recommendations and advice on food consistency. Due to some residents' dependency levels staff assisted these residents with their meals. Staff were observed assisting residents in a sensitive manner and engaged in a positive way with residents throughout the meal. However, staff were not always following recommended guidelines in relation to food and nutrition. For example, one resident had an assessment of their feeding eating and drinking and swallowing (FEDS) completed by the speech and language therapist. This recommended total supervision at meal times and for staff to encourage the resident to have a drink while eating. The resident's personal support plan also outlined that he needed supervision at all times with verbal cues to swallow food. While inspectors were in the dining room these recommendations were not being followed by staff, with verbal cues not being given while the resident was eating and drinks only being provided after the meal.

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:
Medicines management practices required improvement.

Unsafe medicines administration practices were observed, in particular in relation to the delayed administration of antimicrobial medicines and the use of 'rescue' medicines prescribed for the management of epileptic seizures.

Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland.

There was a medicines management policy in place. However, inspectors observed unsafe medicines administration practices. On the second day of the inspection, inspectors intervened at 10.30am as an antimicrobial medicine that was due to be administered at 8.00am had not yet been administered. Inspectors also noted that 'rescue' medicine prescribed for seizures was to be administered when the duration of a seizure exceeds two minutes or for a cluster of three seizures within a 30 minute period. The 'rescue' medicine had not been administered for a seizure which was recorded as lasting five minutes but was given within one minute of a subsequent seizure even though there had only been one seizure in the preceding 30 minutes. Due to the potentially catastrophic and fatal impact of delayed administration of antimicrobials and the misadministration of 'rescue' medicines in the management of epileptic seizures on the vulnerable residents living in this centre, the inspector deemed this to be at a level of major non compliance.

A sample of medication prescription and administration records was reviewed. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications. However, in all medication administration records viewed, the inspector noted gaps where medicines were due to be administered and no reason recorded. This was noted on all three days of the inspection. These medicines included those for the management of diabetes, epilepsy, mental health, constipation and vitamin deficiency. Therefore, it could not be demonstrated that these clinically important medicines were administered as prescribed.

On the third day of inspection medication records for two residents in separate units were noted to have verbal orders received from a doctor over the telephone in relation to a resident need for emergency medication. In accordance with the medication management policy these orders were confirmed by two staff and a documented record of the verbal or telephone order was available to staff who administered the medicine. However, there was no provision in the medication management policy for the medical doctor documenting the written order on the prescription sheet within an acceptable timeframe. This was contrary to the guidance on medication management issued to nurses by An Bord Altranais agus Cnáimhseachais na hÉireann.

Inspectors observed that secure storage was provided for prescription only medicines. A secure system of storage was in place for medicines requiring refrigeration across all units. Staff with whom the inspector spoke confirmed that medicines requiring additional controls (Schedule 2 or Schedule 3 controlled drugs) were not in use in the centre at the time of the inspection. However, the process in place, as demonstrated by staff, for the storage of these medicines was not in line with the Misuse of Drugs (Safe Custody) Regulations.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A written record was

maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

Staff with whom the inspectors spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records.

The inspectors saw and confirmed with staff that no resident was managing his/her own medicines at the time of the inspection. Members of the management team outlined that the tool to be used to support a risk assessment for this practice was under review to meet the requirements of the regulations.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
The HSE, as service provider in this centre, failed to demonstrate that the service provided was safe, appropriate to residents needs or effectively monitored.

During the first two days of the inspection significant non-compliance with the requirements of the regulations were identified and three immediate actions were issued by inspectors:
• it had not been demonstrated that one resident had been provided with adequate food and nutrition for a period in excess of 18 hours
• resident support plans were not being followed in relation to an assessed healthcare need for adequate food and nutrition and the elimination of risk from pressure areas.
• it was not demonstrated that fire evacuation drills considered all likely scenarios and conditions, in particular night time conditions and actual staff arrangements in place

The HSE had put appropriate measures in place to address the deficiencies identified in the immediate action plans. However, the HSE acknowledged that the governance and management arrangements as found on inspection were not satisfactory. In their

response to the immediate action plans relating to a failure to comply with regulation 6(1) and regulation 18(4) the HSE advised that:
1."Management and governance have been reviewed on a unit by unit basis with a particular focus on (unit name). Enhancements have been made to the management and governance structures to ensure consistent and appropriate care for residents. Stringent arrangements for the oversight of same will be in place from today (26 May 2016).
2. Person in charge will base herself on the units to drive clinical guidance improvements and provide support to staff.
3. Provider nominee (on behalf of the HSE) will also spend a portion of working day on units to review and improve documentation and carry out qualitative audits with the support of the Compliance and Regulations Officer and Quality Improvement Teams".

As part of the conditions of registration, since the last inspection there had been a change to the governance structures of the centre. The acting of director of nursing had overall responsibility for the management of three designated centres managed by the HSE on this campus, in addition to a designated centre in the community. The persons in charge of each of the four centres reported to the acting director of nursing.

A new person in charge for this centre had been appointed and had started as a Clinical Nurse Manager III (CNM III) in February 2016. However, inspectors were informed by the representative of the service provider on the third day of the inspection that the person in charge intended to resign her position.

The management team also consisted of a Clinical Nurse Manager II (CNM II) and two Clinical Nurse Managers I (CNM I). The person in charge outlined that the CNM II and the CNM I grade were supernumerary on each shift which meant they were available to support residents wherever their skills were required. However, the management systems as found on inspection did not provide for effective monitoring of the service provided to residents. In relation to the resident who had not received food and nutrition for over 18 hours staff said to inspectors that this was due to inadequate numbers of staff available at that time to assist the resident to get out of bed. However, inspectors were informed that the CNM I was supernumerary on that day but was not called by staff.

For this centre the Chief Inspector had deemed it necessary that the monitoring of the governance and management of the centre by the HSE be applied as a formal requirement, in accordance with Section 65 of the Health Act 2007. The HSE was required to submit a copy of their own analysis of the safety and quality of care and support provided in the centre. The purpose of these reports was to monitor the safety and quality of care and support provided in the designated centre and as required, to put a plan in place to address any concerns identified during the visit. Two such reports had been submitted, one in November 2015 and another in February 2016. The action plan from the quality report in February 2016 had identified 15 actions. However, these reports did not adequately review the safety and quality of care and support being provided in the centre. For example, the report of the unannounced visits did not identify some key failings identified on this inspection such as poor quality of care being provided to residents, unsafe medication management practices, fire safety management and staff rosters not being available to the person in charge.

Between the second and third day of the inspection the HSE as service provider had arranged for a review visit to monitor quality and safety on one of the units. This review visit had taken place between 8 pm and 6 am on 2 June 2016. A draft report was made available to inspectors. This was a comprehensive review and included resident rights, communication, family involvement, admissions, social care needs, premises, risk management, safeguarding, healthcare, medication management and workforce.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Based on observations, a review of the roster and inspection findings, it was demonstrated that the staff numbers were appropriate to meeting the number and assessed needs and abilities of residents. However, an issue was identified in relation to the person in charge having access to the night duty roster. There were also gaps in mandatory training for all staff.

At the opening meeting with inspectors the person in charge outlined that since she started in February 2016 she did not have a copy of the night duty roster despite requesting this on a number of occasions. She outlined that at night there was separate staffing that was coordinated by clinical nurse managers who were rostered to work only at night. The current night time rota was provided to the person in change when inspectors said that it was needed.

In November 2015 there had been a review by the service provider of the "dependence assessment workload index and proposed staffing levels" to make recommendations regarding staffing levels in the centre. This review observed that there were three units in the centre. The review recommended an increase in staffing in one of the units by one care staff and no increase in staffing levels in the other two units. On the date of inspection it was found that there was adequate staffing present. As discussed in more detail in Outcome 14: Governance, the CNM II and the CNM I grade were supernumerary on each shift which meant they were also available to support residents

wherever needed.

A sample of staff files were reviewed by inspectors. It was noted that the provider had not obtained all of the documentation required in Schedule 2 of the regulations for the person in charge of the centre including evidence of vetting by an Garda Síochána, photographic identification, references and job description. Inspectors noted that the person in charge commenced employment in the centre in February 2016. These gaps were brought to the attention of the acting director of services who informed inspectors that the person in charge is on secondment from another service and their personnel file was not transferred with them on commencement of employment.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003999
Date of Inspection:	25 May 2016
Date of response:	14 July 2016

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident's healthcare record had a care plan relating to "bipolar affective disorder and also has dementia". However, there was no definitive diagnosis of dementia recorded in this resident's healthcare file. In addition, there was no baseline assessment for dementia in place for any resident, which meant the service could not track any deterioration in cognitive functioning.

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

1. 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:
• A review of all the care plans including the health support plans has commenced and will be completed by 30/09/16.
• A review of the management systems in place, including the role of the CNMs, was carried out on 14/06/16 and actions to provide effective monitoring of the service provided to residents identified.
• Actions were completed on 11/07/16.
• A process of annual MDT reviews was commenced in April 2016 and will be completed by 30/11/16.

Proposed Timescale: 30/11/2016
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
For residents still living in the centre there was evidence of the inappropriateness of their current living arrangements.

2. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
• Independent skills needs assessments have been undertaken with all residents to identify their current level of functioning and supports required.
• In line with HSE "A Time to Move on from Congregated Settings" policy document this service has an agreed closure date of 31/03/2017 and residents will be supported to live in an environment more appropriate to their needs by this date.

Proposed Timescale: 31/03/2017
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident had recently returned from hospital with recommendations in place from a consultant specialist regarding the management of his care. There was no evidence that these recommendations had been reviewed or implemented.

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

Please state the actions you have taken or are planning to take:
• A review of all the care plans including the health support plans has commenced and will be completed by 30/09/16.
• A review of the management systems in place, including the role of the CNMs, was carried out on 14/06/16 and actions to improve the effective monitoring of the service provided to residents identified.
• Identified actions were completed on 11/07/16.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The HSE had a plan to support resident as they transitioned from the current centre in its congregated setting to a community based model of care. However, the plan was not meeting identified deadlines.

4. Action Required:
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

Please state the actions you have taken or are planning to take:
• A project manager has been appointed and in place since 22/02/16.
• Membership of the Project Board and subgroups is being revisited to include wider representation.
• Family fora facilitated by Inclusion Ireland have commenced and three meetings have been held to date.
• Two houses have now been purchased with a further two houses in the process of being purchased. Viewings are being arranged for another three potentially suitable houses.
• Social Role Valorisation/Supporting Self Directed Lives Training has commenced for five staff members.
• Community Connectors are being appointed to support the transition process and drive the change in how residents are supported, in accordance with HSE Transforming Lives Policy.
• Individual family meetings to be held regarding the transition process.

Proposed Timescale: 31/03/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The process for the management of hazards on the organisation risk register required review.

5. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
• The risk management policy will be reviewed and updated by 30/09/16 to ensure that this policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.
• The process for the management of hazards on the organisation risk register will be reviewed by 30/09/16.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The process for risk assessment required improvement.

6. 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:
• All risk assessments and safeguarding strategies are to be reviewed and updated with the MDT prior to 30/07/16.

Proposed Timescale: 30/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
28(3)(d) It was not demonstrated that fire evacuation drills considered all likely scenarios and conditions, in particular night time conditions and actual staff arrangements in place. In addition, on the third day of the inspection it was observed that the final exit door in an evacuation route from one of the units did not have a key

available which could potentially prevent people from exiting through this door in an emergency.

7. 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:
• A key was provided for the final exit door in an evacuation route from one of the units on 20/06/16.
• A monthly schedule of fire evacuation drills is in place in the centre both day and night and will consider all likely scenarios and conditions.

Proposed Timescale: 12/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Between the second and third day of the inspection a series of fire evacuation drills had taken place, including one on 3 June 2016. During this drill it had been identified that a fire door needed to be connected to the alarm system. However, this had not been completed by the third day of the inspection on 20 June 2016.

8. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
• Fire door was connected to the alarm system on 24/06/16.
• The automatic closure system was fitted on 12/07/16.

Proposed Timescale: 12/07/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the person who was subject to the restrictive procedures was being closely monitored to evaluate the risks to their physical, psychological and emotional wellbeing and to ensure the procedures are minimal in time and in extent.

9. 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:
• The Rights Review Committee has developed documentation to oversee and monitor the application of all restrictive interventions within the centre.
• An application for the use of all restrictive procedures will be submitted to the Rights Review Committee by 31/08/16.

Proposed Timescale: 31/08/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of clarity for staff around the reporting of allegations of abuse.

10. 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:
• The PIC will clarify the reporting mechanism around allegations of abuse at all upcoming staff meetings to ensure that all staff members are aware of the procedure regarding the reporting of allegations of abuse.

Proposed Timescale: 31/07/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
From the records provided by the centre, seven staff had not received training in protecting vulnerable adults; and two staff required updated training on protecting vulnerable adults.

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

Please state the actions you have taken or are planning to take:
• A schedule of staff training regarding the safeguarding and protection of vulnerable adults is on-going in the centre.
• All staff will have completed this training by 31/10/16.

Proposed Timescale: 31/10/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Safeguarding plans were not being followed.

12. 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:
• All Safeguarding plans are in the process of being reviewed in line with the risk assessments and will be completed by the 30/07/16.

Proposed Timescale: 30/07/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
31(1)(f) It was a requirement that all serious injuries were reported to the Chief Inspector within three working days of the incident. However, this requirement was not being complied with.

13. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
• The PIC will ensure that all notifications of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident will be notified to the Chief Inspector within 3 working days.

Proposed Timescale: 04/07/2016

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:
13(2)(b) Residents were observed spending long periods of time not engaged in any meaningful activities throughout their day.

14. Action Required:
Under Regulation 13 (4) (b) you are required to: Ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

Please state the actions you have taken or are planning to take:
• Residents will be engaged in activities that are based on their identified preferences as part of the review of care plans being undertaken.
• Activity audits will be carried out to ensure that residents are being engaged in meaningful activities.

Proposed Timescale: 30/09/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Healthcare support plans were not being followed.

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

Please state the actions you have taken or are planning to take:
• A review of care plans has commenced and will be completed by 30/09/16.
• All healthcare support plans will be reviewed as part of the overall review.

Proposed Timescale: 30/09/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The lack of information regarding the resident’s wardship had potential implications for consent to treatment by the resident.

16. Action Required:
Under Regulation 06 (2) (c) you are required to: Respect and document each resident's right to refuse treatment and bring the matter to the attention of the resident's medical practitioner.

Please state the actions you have taken or are planning to take:
• All information regarding any resident who is a ward of court is held centrally in the Administration office. Any queries with regard same can be raised with the Administrator.

Proposed Timescale: 12/07/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Guidelines and care plans to support residents at mealtimes were not being followed.

17. Action Required:
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:
• A review of all residents' mealtime guidelines was undertaken by the speech and language therapist and nursing staff on 28/06/16.
• Up-to-date guidelines are in place in the centre to support residents with mealtimes.
• A review of care plans has commenced and will be completed by 30/09/16.

Proposed Timescale: 30/09/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident had not been provided with adequate food and nutrition for a period in excess of 18 hours.

18. Action Required:
Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

Please state the actions you have taken or are planning to take:
• A fluid and nutrition intake chart was commenced for all residents on 26/05/16.
• The intake chart system was reviewed on 07/07/16. Any resident identified as requiring this support will continue to have a fluid and nutrition intake chart in place.
• Any resident who wishes to remain in bed after 09:00 will be supported by 15 minute checks by an assigned staff member.

Proposed Timescale: 07/07/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
- Unsafe medicines management practices were observed
- It could not be demonstrated that medicines were administered as prescribed

- The process for ordering emergency medication was contrary to the guidance on medication management issued to nurses by An Bord Altranais agus Cnáimhseachais na hÉireann.

19. Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
• Meeting arranged with the pharmacy provider to discuss audit and staff training on 13/07/16.
• Staff to complete the HSEland Medication management e-learning program.
• Staff to be advised of An Bord Altranais guidelines regarding medication management.

Proposed Timescale: 30/09/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The tool be used to support a risk assessment for self-administration was under review to meet the requirements of the regulations.

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

Please state the actions you have taken or are planning to take:
• Medicines Management policy is currently under review by the policy review group. Policy will be ratified by 15/08/16. Updated policy will include an assessment of capacity to encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.
• All residents in the centre will have a risk assessment for self-administration to include an assessment of capacity for residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Proposed Timescale: 16/09/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The process in place, as demonstrated by staff, for the storage of Schedule 2 and Schedule 3 controlled drugs was not in line with the Misuse of Drugs (Safe Custody) Regulations.

21. Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
• This will be addressed with the pharmacy provider on the 13/07/16. Appropriate actions will be implemented following this meeting based on the advice received.

Proposed Timescale: 30/08/2016

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:
The management systems as found on inspection did not provide for effective monitoring of the service provided to residents.

22. 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:
• An interim PIC commenced in the centre on 04/07/16.
• A review of the management systems in place, including the role of the CNMs, was carried out on 14/06/16 and actions to provide effective monitoring of the service provided to residents identified.
• Identified actions were completed on 04/07/16.

Proposed Timescale: 04/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The HSE was required to submit to HIQA a copy of their own analysis of the safety and quality of care and support provided in the centre. However, these reports did not adequately review the safety and quality of care and support being provided in the centre.

23. 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:
• A comprehensive review of the service provided in one location of the centre was carried out on 02/06/16.
• All areas within the centre will have a comprehensive analysis of the safety and quality of care and support provided in the centre by 16/09/16.

Proposed Timescale: 16/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
At the opening meeting with inspectors the person in charge outlined that since she started in February 2016 she did not have a copy of the night duty roster despite requesting this on a number of occasions. She outlined that at night there was separate staffing that was coordinated by clinical nurse managers who were rostered to work only at night.

24. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
• A planned and actual staff rota is available in the centre.

Proposed Timescale: 12/07/2016