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:	National Association of Housing for Visually Impaired (NAHVI)
Centre ID:	OSV-0001938
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	National Association of Housing for Visually Impaired Limited
Provider Nominee:	Margaret McGovern
Lead inspector:	Anna Doyle
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	2

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 compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
10 January 2017 09:30	10 January 2017 21:22

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This was an unannounced inspection that was conducted in line with HIQA's remit to monitor ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This was HIQA's third inspection in this centre and was carried out by two inspectors over one day. The required actions from the centre's previous inspection carried out in February 2015 were also followed up as part of this inspection.

How we gathered our evidence

As part of the inspection process, inspectors completed a walk through the centre’s premises, spoke with management and staff, and reviewed documentation which included the residents' files, accidents and incidents logs and a number of the centre's policy documents. Inspectors spoke with eight residents.The residents told inspectors that they liked living in the centre and spoke of activities they were involved in such as horse riding, cooking, music lessons, concerts and work experience. One resident went through their personal plan with inspectors and another spoke to inspectors about their transition to the centre.Two residents were not in the centre on the day of the inspection.

Additionally, in assessing the quality of care and support provided to residents, the inspectors spent time observing staff engagement and interactions with residents. Overall, residents appeared happy and content in their home.

Description of the service
The centre was established to provide supported living to adults with vision impairment, and with additional support requirements. The designated centre was made up of four houses, across two locations in County Dublin but in close proximity to each other. The two locations were close to amenities such as shops, gyms, restaurants, banks and bus stops. The centre was home to 18 male and female residents over 18 years of age.

Overall judgment of our findings
The inspector observed residents to be content and interacting with staff in a relaxed and friendly manner. However, inspectors' identified significant failings in regard to safeguarding, healthcare needs, medication management and areas for improvement including; contracts of care, personal plans, fire management and policies. In addition, inspectors found that the three actions identified in the previous inspection had not been implemented to a satisfactory level.

Of the nine outcomes inspected against: three outcomes were found to be in major non compliance - safeguarding, healthcare needs and medication management. Four outcomes were found to be of moderate non-compliance and two outcomes were found to be substantially compliant.

All inspection findings regarding compliance and non compliance are discussed in further detail within the inspection report and accompanying action plan.

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

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Inspectors reviewed a sample of residents' files and found that the centre had written agreements in place with each resident. However, the written agreements in place did not include the details of the services to be provided and the fees to be charged in line with Regulation 24. This was identified in the previous inspection. The centre had developed a draft contract of care and supplied a copy to the inspectors.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Overall, inspectors found residents had opportunities to engage in meaningful activities in line with their interests. However, some improvement was required to the arrangements in place to meet the assessed health care needs of residents and to ensure that assessments of need were in place and subject to an annual review for some residents.

Inspectors found residents had opportunities to engage in meaningful activities in line with their interests. Some resident attended a day service and an activity plan was in place for residents who did not attend day services. In addition, there was a number of prefabracated buildings (seomras) to the rear of two of the houses to facilatate activities such as computers and relaxation therapy.

Long term and short term goals were developed with residents participation. Inspectors found that the goals identified were personalised and residents spoke positively about their goals and plans with inspectors. Some of the goals included flying lessons, attending concerts, computers, holidays, attending matches, independent travel and work experience. The goals were reviewed on a monthly basis by the resident and their one to one staff to ensure progress towards the goal. Inspectors observed residents preparing meals, going to the gym and receiving music lessons on the day of inspection.

Inspectors reviewed a sample of residents' personal plans. Inspectors found that the comprehensive assessment of the health, personal and social care needs were not subject to an annual review. One comprehensive assessment reviewed had not been updated since June 2014.

An annual review was completed with residents, their representatives and staff to discuss goals, healthcare and any other needs. However, inspectors found that the records viewed did not demonstrate that there was multidisciplinary input or whether the review assessed the effectiveness of the overall plan.

Inspectors found that there was no clear process of supporting admissions into the centre. There had been three recent admissions since the last inspection. Inspectors reviewed the file of one recent admission and there was no transition plan in place and the personal plan was not completed within 28 days as specified in the regulations. However, the resident discussed the transition process with inspectors and stated they were happy with the transition. Inspectors also reviewed documentation post inspection demonstrating that the current residents were informed of the new admission.

Assistive aids and technology were provided to support residents with daily tasks. For example, liquid level indicators for cups and containers and a 'talking' microwave. There was a key fob entry system and intercom system for answering the door in place.

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):
No actions were required from the previous inspection.

Findings:
Overall, inspectors found that the systems in place to promote the health and safety of residents, visitors and staff were in place. However, the areas of risk management and fire safety required improvement.

The centre had a health and safety statement which outlined the responsibilities of the various post holders within the organisation.

The centre had a risk management policy in place however it did not include the four risks specified in Regulation 26. This is actioned under Outcome 18. The centre maintained a risk register which outlined a number of risks in the centre and the controls in place to control the risk. The risks outlined in the risk register included slips, trips & falls, access to professional services and medication. The centre also had individual risk assessments in place which included fire, behaviour and independent travel.

Inspectors reviewed a sample of incidents and found that there was a clear system of recording and follow up.

There were arrangements in place for fire safety management. There was certification to show that the fire alarms, emergency lighting and fire equipment were serviced on a regular basis. The centre also had sensory equipment in place as needed to alert residents of a fire such as vibrating pillows. Staff and residents spoken with were able to tell inspectors what to do in the event of a fire. The centre completed regular fire drills and inspectors reviewed the record of these drills. Personal Emergency Evacuation Plans (PEEPs) were in place for each resident which reflected the resident's mobility and cognitive understanding. However, some improvement was required. The procedures to be followed in the event of fire were not displayed in a prominent place in the units of the centre. In addition, inspectors found that fire doors were not in place in all units of the centre.

The centre had procedures in place for the prevention and control of infection. Inspectors observed personal protective equipment and hand wash facilities located throughout the centre. Inspectors found the premises to be clean and hygienic. The inspectors reviewed the cleaning schedule which included the involvement of residents.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Overall, the inspectors found that there were some measures in place to protect residents from being harmed or suffering abuse. However, there was some improvement required with behaviour support plans, safeguarding, policies and restraint practices.

The centre recognised the need for a restraint free environment for residents but improvements were required to ensure all restrictions were identified, monitored, supervised and reviewed in line with national guidelines. The centre did not have a policy in place on the use of restrictive procedures and physical, chemical and environmental restraint. Inspectors identified two restraints in place in the centre which involved the locking of particular foods away and a physical hold. These were not recorded or reviewed as restrictive practices. The restrictive hold that had been implemented recently for one resident had not been subject to review.

Inspectors found that the centre's policy on behavioural support did not guide practice. For example, the policy guided staff on the use of sanctions which the centre manager stated is not in practice. The inspectors found that residents' positive behaviour support needs were recognised, assessed and supported. Behaviour support plans were in place as appropriate. Inspectors examined a sample of plans and found that they were detailed and described the behaviour, triggers, preventative and reactive strategies. However, the behaviour support plans did not adequately outline the supports required for some residents. For example, one behaviour support plan did not guide staff as to when a MAPA hold should be used.

Staff interactions with residents were observed to be person centred, warm and respectful. Residents were noted to be relaxed and contented in their home. Residents told inspectors they felt safe in the centre. A visitors book was also maintained to record visitors to the centre.

The centre had systems in place for responding to any incidents, allegations and suspicions of abuse. Staff spoken with were knowledgeable on what constitutes abuse and the procedure in place. They could outline how they would respond to potentially

abusive situations for residents and were clear regarding their reporting responsibilities. However, not all staff had up to date training in safeguarding vulnerable adults.

Intimate care plans were in place for all residents and inspectors reviewed a sample of these plans. The plans guided staff in providing intimate care in accordance with the residents' assessed needs and wishes.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that there was no comprehensive assessment of need in place for residents healthcare needs and that there was no health care support plans in place in order to guide practice.

A sample of personal plans were viewed by inspectors. In addition to this, inspectors spoke with staff and one resident went through their personal plan with inspectors. From the information gathered, inspectors found that staff were unclear about some residents' healthcare needs. For example, inspectors requested information from staff around four different residents healthcare needs and the staff responses were not clear about either the supports in place for the resident or the nature of the healthcare need.

In the absence of documentary evidence, the inspectors could not ascertain the care and support in place, or required, to meet identified healthcare issues. In addition, the inspectors were not assured the care provided was consistent, monitored effectively and in line with best practice.

Allied health professionals were available to residents and were accessed through community services or services were bought in by the provider as necessary. The allied health professionals involved in the residents care was listed in the front of their personal plans. However, it was unclear from the records maintained how often residents accessed these services, some residents were able to tell inspectors about upcoming appointments they had with allied health professionals.

Meal times were not observed as part of this inspection. However, residents spoken to were happy with the meals provided in the centre and informed inspectors that if they

do not like the menu for the day, that alternatives were always available. Residents also spoke to inspectors about their own involvement with meal preparation in the centre.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that the medication management systems in place in the centre were not adequate so as to protect residents and guide practice.

The policy available in the centre on the day of the inspection did not include the procedures for the storage of all medications in the centre, the disposal of medication in the centre and did not accurately reflect the practices in the centre. In addition, inspectors found that some of the practices in the centre were not in line with best practice.

The prescription sheet for residents in the centre was a general medical services prescription issued by the residents GP in order for the pharmacist to dispense the correct medication for the resident. Inspectors found that this prescription sheet did not include the residents date of birth, the route of administration, the time of administration and a GP signature was not completed for all medications prescribed. Medication that required crushing was not signed off by the prescribing doctor.

As required medication (PRN) were not recorded on the prescription sheet. For example, inspectors found that each resident had a consent form contained in their plans that had been signed by the resident and their representative. This form listed a number of over the counter prescriptions that could be administered to residents by staff. However, the residents GP had not signed off on these medications and there were no clear guidelines for staff around when they should be administered.

Inspectors also found that residents had been administered some medication that was not listed on the consent form. In addition, the indications for use of some prescribed medications was inconsistently recorded. For example, rescue medication that was prescribed for epilepsy had inconsistent information recorded and staff spoken to were not clear about the administration of it.

Short term medications were not always included on a prescription sheet that was signed by the residents GP. For example, one resident who had been administered a short term medication by staff had no prescription sheet in place. When inspectors requested confirmation of the prescription from the GP, they were given a note that had been submitted and signed by the residents representative.

Drug administration recording sheets were formulated from the information contained on the general medical services prescription by the person in charge and the provider. Inspectors found that some of the medication dosages written on this were not the same as the information on the prescription sheet. For example, some medication was written in millilitres as opposed to micrograms. In addition, to this inspectors found that staff used the administration sheet to check residents prescribed medications as opposed to the prescription sheet.

Medications were stored in a locked press in each unit of the centre. However, some medications stored were not labelled with the residents name on it and some prescribed creams had no date of opening recorded on them. Some medications were stored in a domestic fridge in the centre and while some were stored in a locked box within the fridge, others were not. The inspectors found that there was no policy in place around this and that some of the medication was therefore not securely stored in the centre.

Medicines were supplied by a retail pharmacy business, and were appropriately dispensed in individual 'pouches'. There was a system in place whereby two staff members checked the medications delivered from the pharmacy. A record was also maintained of any medications that could not be dispensed in individual pouches.

Some staff had not completed training on the safe administration of medication. These staff were administering medication with other staff members who had medication training. However. the policy stated that only staff who were trained in the area could administer medications in the centre.

Inspectors also found that staff were not familiar with some medications prescribed for residents.

A sample of medication error records were viewed by inspectors, however the information contained on them was incomplete. For example the nature of the error was not completed in full.

There were no controlled drugs stored in the centre.

Some residents self administered medication in the centre. The policy stated that residents should have a risk assessment completed to this regard. Inspectors found that while this was in place that some residents were still been supervised by two staff while administering their medication even though residents had been independent in this area prior to admission to the centre.

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:
Overall, the inspectors found that the centre had a defined management structure and some systems in place to monitor the service provided. However, improvements were required to ensure that the service provided were effectively monitored and support the delivery of safe and appropriate care for residents.

The inspectors reviewed the 2015 annual review which was completed according to the themes with correlating areas for improvement identified. The review included consultation with the residents and their representatives and staff regarding the quality and safety of care and support in the centre. The annual review for 2016 was in process of being finalised.

The provider completed six-monthly unannounced visits of the centre to review the safety and quality of care and support provided in the centre. The six-monthly reports were broken up into three sections: health and safety, quality of care and action plan.

The centre had some formal audit systems in place to monitor medication, hygiene and transport vehicles. The centre manager informed inspectors that informal audits on personal plans were carried out. However, the findings of this inspection demonstrate that audit and monitoring systems require improvement.

There was a clear management structure with lines of authority and accountability. Inspectors reviewed the minutes of weekly staff meetings and of meetings between the PIC and the provider. Staff spoken with were found to be clear regarding the reporting structures within the centre.

The inspectors found the centre was managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service. The person in charge managed the four units of the centre. She was involved in the day to day operational management of the centre. She had a good knowledge and understanding of the residents. Residents were able to identify her and the provider.

Judgment:
Substantially Compliant

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

Theme:
Responsive Workforce

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

Findings:
Overall, inspectors found that there was an appropriate staffing level to meet the assessed needs of the residents in the centre. However, improvements were required in relation to the staff roster and staff training.

The centre maintained a planned and actual roster. Inspectors reviewed a sample of the roster and found the roster did not contain full names of staff. The roster demonstrated that there was an appropriate staffing level to meet the assessed needs of the residents in the centre. The centre has on call support from the service manager and access to nurse personel was available if required.

Inspectors found that staff were supervised through regular team meetings, an annual appraisal system and the person in charge worked on the floor. Staff spoken with felt supported by the management of the centre. Staff members' interactions with residents were observed to be person centred and positive.

Inspectors reviewed a sample of staff training. Not all staff had up to date training in safeguarding. In addition, inspectors found that not all staff had training to meet the assessed needs of the residents. For example, staff were not trained in diabetes management.

Inspectors did not review staff files during this inspection as the previous inspection found that staff files met the requirements of Schedule 2.

There were no volunteers active in the centre.

Judgment:
Substantially Compliant

Outcome 18: Records and documentation

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

Theme:
Use of Information

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

Findings:
Inspectors found that the action in relation to policies and procedures from the previous inspection was not addressed

The centre did not have all the written operational policies in place as required by Schedule 5 of the Regulations and some polices requred impriovement. For example:
- There was no policy in place forany incidents where a resident goes missing and
- There was no policy in place for the use of restrictive procedures and physical, chemical and environmental restraint.
- The admission policy in place did not contain details on transfers and temporary absence of a resident
- The risk management policy did not outline the four risks specified in Regulation 26.
- The medication management did not outline storage of medication
- The finace poloicy did not guide practice.
- The policy on vulnerable adults which included prevention, detection and response to allegation of abuse and behavioural support was in draft format.

During the course of the inspection, inspectors found records were not adequately maintained. For example, several documents reviewed were not dated.

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:

Anna Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by National Association of Housing for Visually Impaired Limited
Centre ID:	OSV-0001938
Date of Inspection:	10 January 2017
Date of response:	23 February 2017

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 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:
The written agreements in place did not include details on the provision of services and details of the fees to be charged.

1. Action Required:

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

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:
A new draft contract has been submitted to the Board of Management. This will be posted out to the Residents and their Parents/Guardians for their perusal. It is hoped that all contracts will be signed and completed by March 3rd 2017

Proposed Timescale: 03/03/2017

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:
The records viewed did not demonstrate that there was multidisciplinary input.

2. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
Both the PIC and Service Provider Nominee will implement a new assessment of need format to include multidisciplinary input. A new assessment of need will be completed with all residents by the PIC and Service Provider Nominee.

Proposed Timescale: 14/05/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents had a personal plan developed no later than 28 days after admission.

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

Please state the actions you have taken or are planning to take:
On the date of inspection there was a care plan in place, but it was not complete. This has been rectified. However this care plan will also be reviewed as part of the assessment of need format.

Proposed Timescale: 14/05/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The records did not demonstrate whether the annual review assessed the effectiveness of the overall plan.

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

Please state the actions you have taken or are planning to take:
The new assessment of need format to be completed by the Service Provider Nominee and PIC will include an annual review with all residents. The new template was completed by compiling the themes of the National Standards. A list of questions has been made based on these themes. It is hoped that by doing this that all areas will be encompassed by the review. We will also be using a new Support plan template which will accompany the assessment of need. There will be specific areas of responsibility. It is hoped that by doing this that a greater level of accountability and effectiveness will be achieved. Two Social Care Workers have been nominated on the staff team to oversee file audits and to assist the other staff members with their paperwork.

Proposed Timescale: 14/05/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One comprehensive assessment reviewed had not been updated since June 2014.

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

Please state the actions you have taken or are planning to take:
An annual review of all residents will be completed by the Service Provider Nominee by May 14th 2017

Proposed Timescale: 14/05/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The procedures to be followed in the event of fire were not displayed in a prominent place in the units of the designated centre.

6. Action Required:
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

Please state the actions you have taken or are planning to take:
A fire evacuation map for each house in the designated centre is being sourced from our fire safety consultant. It is hoped that these will be in place and on display by February 24th.

Proposed Timescale: 24/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire doors were not in place in all units of the centre as appropriate.

7. 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:
A fire audit was completed by an external party before registration highlighting where fire doors may be required. As it was not a requirement at the time of registration fire doors were not put in place, extra funding will be required to do this. It is a matter of ongoing concern; the Board of Management are currently reviewing this in order to rectify the non-compliance. It is hoped that the issue will be addressed by year end.

Proposed Timescale: 31/12/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Behaviour support plans did not include all interventions in place.

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

Please state the actions you have taken or are planning to take:
The new assessment of need format will include support plans on every aspect of the residents needs including behavioural. These plans will detail all interventions that are in place for each individual resident.

Proposed Timescale: 14/05/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices were not reviewed in the centre.

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:
This is currently being reviewed and it is hoped that a restrictive practice policy will be in place by March 10th 2017. The new policy will work in conjunction with our behaviour support plans. The policy states that the behaviour support plans should be reviewed at a maximum of six monthly intervals.

Proposed Timescale: 10/03/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date training in safeguarding vulnerable adults.

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

Please state the actions you have taken or are planning to take:
The two staff members who did not have training in safeguarding vulnerable adults have now completed Children's First training.

Proposed Timescale: Completed

Proposed Timescale: 23/02/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no comprehensive assessment of need in place for residents healthcare needs.

There were no health care support plans in place in order to guide practice.

Staff were unclear about some residents' healthcare needs.

In the absence of documentary evidence, the inspectors could not ascertain the care and support in place, or required, to meet identified healthcare issues.

The inspectors were not assured the care provided was consistent, monitored effectively and in line with best practice.

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

Please state the actions you have taken or are planning to take:
The new Assessment of need format will comprehensively include individual health care support plans to guide practice. Two Social Care Workers on the staff team have been nominated to oversee file audits. These audits will include the healthcare support plans. The PIC and Contingency PIC will also be completing audits. A training session is also being provided to all staff in relation to the health care needs of all residents.

Proposed Timescale: 14/05/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was unclear from the records maintained how often residents accessed allied health professionals involved in their care.

12. 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:
The record system that is in place to record appointments will be updated to include a cover sheet illustrating clearly all health care appointments.

Proposed Timescale: Completed

Proposed Timescale: 23/02/2017

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:
There was no policy in place around the storage of all prescribed medications in the centre.

Some of the prescribed medications were not securely stored in the centre.

13. 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:
A Policies & Procedures Committee meeting was held on February 15th last. The issues which are raised above are being addressed within the policy. The medication policy is under review. SAMS training will be completed by all staff by March 1st 2017, at which point the service will look at implementing a Kardex system which it is hoped will address issues in relation to the ordering, receipt, prescribing, storing, disposal and administration of medicines.

Proposed Timescale: 14/04/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The prescription sheet did not include the residents date of birth, the route of administration, the time of administration and a GP signature was not completed for all medications prescribed.

Medication that required crushing was not signed off by the prescribing doctor.

The residents GP had not signed off on as required medications and there were no clear

guidelines for staff around when the medications should be administered.

The indications for use of as required prescribed medications was inconsistently recorded.

Short term medications were not always included on a prescription sheet that was signed by the residents GP.

Medication dosages written on the drug administration recording sheet were not the same as the information recorded on the prescription sheet.

Staff were not familiar with some medications prescribed for residents.

Staff were administering medications using the drug administration recording sheet and not the prescription sheet.

Some medications stored were not clearly labelled.

Prescribed creams/drops did not have a record of the opening date.

Some staff had not completed training in safe administration of medication.

14. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Medication which required crushing has now been signed off by the GP. SAMS Training and Buccolam Midazolam will be completed by all staff by March 1s at which point the service will implement a Kardex system. The local GP has agreed to sign off the Kardex system. The medication policy is also under review. As a result of the inspection. It is hoped that by doing these things that the above issues will be addressed.

Proposed Timescale: 30/04/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no policy in place around the disposal of unused or out of date medication in the centre.

15. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored

in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
The Medication Policy will be amended to include the disposal of medication.

Proposed Timescale: 31/03/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents who self medicated in the centre were being supervised by staff despite the fact that residents were able to do this independently prior to their admission to the centre.

16. 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:
The resident in question is completing a risk assessment for self-medicating and a self-medicating procedure is currently been devised.

Proposed Timescale: 10/03/2017

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:
A number of non compliance identified during the inspection specifically in relation to safeguarding, healthcare needs and medication management indicated the management systems in place did not ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

17. 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:
Two Social Care Workers from the staff team have been nominated to oversee audits

on all resident files including the monitoring of healthcare needs. It is hoped that with the completion of SAMS and Buccolam Midazolam training and the implementation of the Kardex system that this will rectify these issues. The PIC and Contingency PIC have completed full medication audits since the day of inspection and they will oversee the implementation of the Kardex system. The PIC and Contingency PIC will also complete service audits. The Service Provider will also be completing service audits as per their regulatory obligation. At present there are a number of audits completed on a weekly basis. These include medication stock take, fire equipment and emergency lighting. A transport audit is completed on a monthly basis.

Proposed Timescale: 14/05/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roster did not contain full names of staff.

18. 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:
All staff rosters have been amended to include full staff names.

Proposed Timescale: Completed

Proposed Timescale: 23/02/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up-to-date mandatory training in safeguarding

19. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
The two staff members who did not have training in safe guarding vulnerable adults have since completed it.

Proposed Timescale: Completed

Proposed Timescale: 23/02/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have all the policies as required by Schedule 5 in place as outlined in the report.

20. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:
These policies are now in draft form and will be completed by 14th of May.

Proposed Timescale: 14/05/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the residents' records were not adequately maintained.

21. Action Required:
Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

Please state the actions you have taken or are planning to take:
Record keeping training will be provided for all staff.

Proposed Timescale: 07/07/2017