**Health Information and Quality Authority
Regulation Directorate**

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

Centre name:	Dolmen House
Centre ID:	OSV-0002067
Centre county:	Carlow
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	BEAM Housing Association Ltd.
Provider Nominee:	John Murphy
Lead inspector:	Lorraine Egan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
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 1 day(s).

The inspection took place over the following dates and times

From:	To:
03 November 2016 11:30	03 November 2016 21:00

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

Outcome
Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
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 monitoring inspection was carried out to monitor compliance with specific regulations and to assess if the provider had addressed the actions from the previous inspection.

How we gathered our evidence:
As part of the inspection the inspector met with three residents. One resident was not in the centre on the day of inspection.

Residents spoken with told the inspector they were happy when staying in the centre, had adequate staff support and were supported to live as independent lives as they wished. The only negative comment made by residents was that the centre closes at weekends which some felt impeded their lives. The inspector noted that the centre was providing a service to residents who required minimal care and support.

The inspector also spoke with the person in charge of the centre and reviewed

documentation such as residents' support plans, medical records, accident logs, policies and procedures and staff files.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. In the areas inspected, the inspector found that many aspects of the service were provided as described in that document.

The centre was located within walking distance of a town centre and amenities. Residents walked, cycled and used public transport. In addition, the organization provided transport when available.

The house contained adequate private and communal space to meet the needs of residents. Residents had individual bedrooms and shared bathroom, kitchen, dining and living space when staying in the centre. The centre met residents' assessed needs in regard to the physical premises.

The service was available to men and women with intellectual disabilities between the ages of 18 and 65 who could demonstrate their ability to live relatively independent lives. It opened from Monday afternoon until Friday morning. Residents stayed in the centre for a maximum of four nights each week and paid a set fee which was calculated on the number of nights. The fee paid included all utility bills.

Overall judgment of our findings:
The inspector found the provider had not implemented an effective system to ensure the service provided to residents was effectively monitored. However, the impact on residents was minimal due to the low support needs of residents living in the centre at the time of the inspection.

Notwithstanding this the inspector noted that there was a risk that if residents' needs changed, or if there was a new admission to the centre. The provider did not have systems to ensure residents' needs were assessed and to ensure appropriate care and support was provided.

The provider nominee and the person in charge were required to take immediate action on the day of inspection as they had failed to ensure all staff working in the centre had Garda vetting in place. The findings and the immediate response is outlined in outcome 17.

In addition, improvements were required in the following areas:

- Complaints procedure (in outcome 1)
- Service agreements (in outcome 4)
- The assessment of residents' health, personal and social care needs (outcome 5)
- The measures to ensure the centre is consistently kept in a good state of repair internally (outcome 6)
- Risk management and fire safety measures (in outcome 7)
- Provision of training for staff and supervision of staff (in outcome 17)
- Policies and procedures (in outcome 18)

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
The inspector reviewed the actions required from the previous inspection. The person in charge said the national advocacy service was used if a resident required or requested an advocate. Residents told the inspector they were able to raise issues themselves and were supported by family if they needed support.

Residents were independent in managing their finances. Residents told the inspector they were supported by family where they required support. Residents had set up a 'kitty' system to pay for shared items such as groceries. The residents maintained a ledger outlining the amount spent and receipts for items.

There was a policy and procedure in place for responding to complaints. The inspector was told no complaints had been received and residents stated they had not made any complaints. Residents told the inspector they were treated with respect and knew how to make a complaint if they were not happy with any aspect of the service provided. Residents gave examples of things they had discussed with staff and the person in charge and the outcomes which were resolved to their satisfaction.

The procedure for responding to complaints did not identify the person with responsibility for ensuring that all complaints are responded to and a record of complaints maintained. In addition, the procedure did not include a procedure for appealing the outcome of a complaint and stated that complainants could choose to complain to HIQA. As HIQA does not have a legal remit to investigate individual complaints this information was inaccurate.

These items were discussed with the person in charge who said the provider nominee held the role of ensuring complaints are responded to and records maintained. She stated that the procedure would be amended to ensure it was effective and clearly outlined the roles and responsibilities held by the person in charge and provider nominee and included a procedure for appealing the outcome of a complaint.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
The inspector reviewed the actions required from the previous inspection.

Individual service agreements were in place for three residents. However, one resident did not have a service agreement.

The inspector read the service agreements and saw they included the service provided and fee paid by residents. Information in the service agreements which outlined the appeals process for the management of complaints was inaccurate. It stated residents could contact HIQA if they were not satisfied with the outcome.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Residents were supported to live independent and fulfilling lives. However, the system to support this was not effective. A comprehensive assessment of each resident's health, personal and social care needs had not been carried out annually as required by the regulations.

It was evident that residents were independent in many aspects of their health, personal and social care needs. Residents said that they had opportunities and were supported to live meaningful lives. Residents engaged in employment, third level college courses, attending training programmes and leisure activities such as swimming, bowling and attending the theatre. However, the lack of a system to ensure residents' needs were assessed and responded to had the potential to impact negatively on residents if changes in support needs or wishes were not identified and responded to.

Each resident had a person centred plan which included an assessment of their social care needs. However, these plans were dated between October and December 2014. The inspector read some plans and noted that goals had been identified. However, residents' long term aspirations, which were documented in the plans, had not been identified as residents' goals. When speaking with residents they raised the same long term aspiration as a goal. All residents spoken with stated that they wanted the centre to open seven days per week. This had not been identified as a goal for residents.

The goals identified in the plans had not been reviewed and there was no rationale as to why the documentation was blank with no person identified to ensure that residents were supported to achieve the goals identified and any barriers to the achievement would be identified and resolved.

As outlined further in outcome 11 there was no assessment of residents' healthcare needs. The person in charge showed the inspector a template of a healthcare assessment which the organization were considering implementing. She said it was envisaged this would be implemented in the centre.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is

appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The centre was a single storey house in a housing estate located within walking distance of the town and amenities. It had been purpose built by the provider and contained adequate communal and private space to meet the needs of residents. Some improvement was required to ensure all aspects of the centre were maintained to a good standard.

The centre comprised of a kitchen/dining room, sitting room, conservatory, bathroom and four bedrooms. There was a large enclosed back garden.

Each resident had individual bedrooms which they had decorated to their preference. There was adequate storage in each bedroom and lockable storage if residents wished to store items of value to them.

There was a large bathroom with an accessible shower and assistive equipment such as assistive rails on the walls and a shower chair.

The inspector was told that maintenance was provided by the provider, for example changing bulbs and fixing broken items.

The heating system could not be operated in the house. The operating system was in the adjoining house which was not used as a residential centre. Staff had access to this house when they were on duty. Although it was cold on the evening of the inspection residents told the inspector they were not cold and said they light the fire in the sitting room in the evenings. The inspector was told the provider was fitting a stove in the sitting room in place of the open fire in the coming weeks. The person in charge told the inspector the central heating would be adjusted to ensure the house is warm for residents.

The inspector was told residents cleaned the house with the support of staff. Some improvement was required to ensure the centre was kept in a good state of repair on an ongoing basis. The inspector was told there was no system to ensure the centre had a 'deep clean' and to paint rooms in the centre as required. The inspector noted some areas which had a build up of dust and some walls which had marks and paint flaking. In addition, an assistive rail in the bathroom contained a significant amount of rust.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There were some systems to ensure the health and safety of residents, staff and visitors were promoted and protected. Improvement was required to the system to ensure all risks were identified and control measures implemented and that all fire safety systems were implemented.

There was a risk management policy which outlined the measures to be taken to ensure the health and safety of residents was protected and promoted. The policy stated that risk assessments and care plans should be reviewed every three months. However, there was no system in place to ensure this was adhered to. The inspector found that residents' plans and assessments were not reviewed every three months.

Although fire drills had taken place it was not evident that all reasonable effort had been made to ensure residents were aware of what to do in the event of a fire at night. This was particularly relevant as residents did not require staff support at night. Fire training drills had taken place with residents in October 2016, June 2016, April 2016 and December 2015. However, a fire drill had not taken place at night. Residents spoken with said the intruder alarm had activated at night in 2014 and said they had evacuated the house at that time. The residents said they could see that it would be useful to participate in a drill at night.

There was a fire safety folder in the centre. The folder contained the system and documents to show all equipment was serviced and regular checks were carried out on all aspects of fire safety. While some documentation showed the system was adhered to, for example weekly checks of the fire doors and exits, other checks were not documented as completed consistent with the frequency outlined. For example, monthly checks of fire extinguishers and fire blankets and a weekly check on the emergency lighting were not documented as completed as frequently as required.

On the day of the inspection it was not evident the fire alarm had been serviced on a quarterly basis which was outlined, by the external fire safety company, as required. Evidence of this was not contained in the fire safety folder. The day after the inspection a record dated 04.07.2016 was emailed to the inspector. This record stated the alarm had been serviced on 24.11.2015 in quarter one, 22.02.2016 in quarter two, 04.07.2016 in quarter three and 27.07.2015 in quarter four. The week after the inspection the person in charge submitted a record showing the alarm had been serviced on

07.11.2016. These records therefore did not evidence that the fire alarm was consistently serviced on a quarterly basis.

The annual servicing of the emergency lighting had taken place in February 2016. The fire fighting equipment had been serviced in October 2015. The inspector was told a service had been scheduled for the week following the inspection. The week following the inspection the person in charge submitted the certificate showing the fire fighting equipment had been serviced.

The intruder alarm was serviced on a six monthly basis and the CCTV (closed circuit television) system had been serviced. There was no assistive equipment in use in the centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse.

There were measures in place to keep residents safe and protect them from abuse. The person in charge spoke of their role in implementing systems to safeguard residents and in supporting staff who may disclose a suspicion or receive an allegation of abuse. She said all allegations would be investigated and notified to HIQA. No allegations of abuse had been received at the time of the inspection. An allegation of abuse was made in the days following the inspection and this was notified to HIQA.

The person in charge spoke of residents with respect and warmth. They were aware of what abuse is and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to.

Residents living in the centre did not require support with their personal intimate care.

There were no residents who required support with behaviours that challenge. The person in charge said that all required support would be provided if any resident required this support.

There were no restrictive practices in the centre.

Judgment:
Compliant

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

Theme:
Safe Services

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

Findings:
A record of incidents was maintained in the centre. The person in charge was knowledgeable of the requirement to maintain a record of all incidents occurring in the designated centre and, where required, to notify the Chief Inspector.

Judgment:
Compliant

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:
There was no assessment of residents' healthcare needs. The inspector was therefore unable to ascertain if residents were supported to achieve and enjoy the best possible health. However, the inspector did note that residents living in the centre were independent or supported by family in regard to their healthcare needs and that the

person in charge was knowledgeable of changes in residents' healthcare needs. The inspector therefore made the judgment that the non-compliance with the regulations in relation to this was a non-compliance with Regulation 5 as it related to the assessment of need as opposed to meeting residents' needs. For this reason the action related to this is included in outcome 5.

Residents attended a general practitioner of their choice and allied health professionals as required. The inspector read some documentation which showed that residents were independent or supported by family members to attend medical appointments. There had been an improvement in the documentation of this information since the previous inspection. The provider had implemented a system to ensure all relevant information was received from residents when they returned to the centre on a Monday or following an absence. Staff spoke with each resident individually and documented any changes or updates in the resident's folder.

Residents purchased groceries and prepared their own meals. Residents told the inspector they each took responsibility for carrying out different roles in the centre with some residents preferring to prepare meals. Residents told the inspector they had joined a slimming club which they attended together on a weekly basis. The residents had lost weight and told the inspector they enjoyed making meals which were healthy and consistent with the slimming plan.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
The centre had procedures for supporting residents to administer medicines safely and to provide support where required.

Residents had completed competency assessments and had been assessed as competent to self-administer their medicines. Each resident stored their medicines in their bedrooms and had individual safes to store medicines.

A copy of the original prescription was in place for the sample of medicines viewed and each resident had a prescription sheet outlining the prescribed medicine, dose, time of administration and a maximum dose was specified for p.r.n (a medicine only taken as

the need arises) medicines.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
As outlined in outcomes 4, 5, 6, 7, 8, 17 and 18 the provider had not implemented an effective system to ensure the service provided to residents was effectively monitored. Some actions arising from the previous inspection of the centre and actions arising from the review of the quality and safety of care in the centre had not been addressed.

An unannounced visit to the designated centre had not been carried out since the commencement of regulation.

One review of the quality and safety of care in the centre had taken place since the commencement of regulation. The review was dated 06 February 2015 and had been carried out by an external company. Areas for improvement had been identified. These included the absence of recording fire drills and fire checks; key policies not in place; formal recorded supervision of staff not in place; key risk assessments not in place; and incomplete individual plans. There was no evidence these areas had been addressed and the action plan at the back of the report was blank. The inspector's findings evidenced that these areas were not addressed by the provider.

The annual review included a section on residents' views. Residents were complimentary of staff, how to make a complaint and day to day support provided. However, some queries were raised by residents and there was no evidence these were discussed with residents and addressed.

A record of questionnaires completed by family members was contained in the review. Although the majority of the comments were positive, and complimentary of the service provided, some concerns were raised and there was no evidence that these had been

responded to.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
There were appropriate staff numbers to support residents. However, the provider had not implemented an effective system to ensure the information required in Schedule 2 of the regulations, including the requirement for Garda vetting, was obtained for staff working in the centre.

The provider was required to take immediate action in relation to Garda vetting on the day of inspection. In addition, the formal system for supervising staff was not implemented, there was no planned or actual staff rota, a centre specific training needs analysis had not been carried out and some staff had not received all required training.

Staffing numbers and skill mix:
Support staff worked in the centre for three hours each evening. Residents spoken with outlined the areas they required support with and said they were happy with the hours provided. The person in charge outlined the role of staff and said the support was directed by the needs and wishes of residents.

The provider had completed an assessment of residents' support needs using a recognised assessment tool. The inspector was told this information was used to ascertain the required staffing levels. The inspector reviewed these and found residents had low support needs. However, the assessment for one resident was not available on the day of the inspection.

Staff files:
The inspector viewed staff files and found some information had not been obtained. A full employment history had not been obtained for two staff members and written references had not been obtained for one staff member. Furthermore, evidence of

Garda vetting had not been obtained for one staff member. The staff member's file contained a letter showing the Garda vetting had been applied for, however the staff member had been working in the centre while the provider was waiting for the vetting.

The person in charge was required to outline an immediate response to this and contacted the provider nominee by phone. The initial response outlined to the inspector was for the staff member to work the scheduled shift the evening of the inspection. However, following further discussion with the provider nominee the person in charge told the inspector that an alternative staff member would work in the centre that evening. In addition, the inspector was informed that Garda vetting would be obtained for all staff prior to them working in the centre. The inspector requested this in writing from the provider and received this the day after the inspection.

Staff supervision:
The person in charge said the formal system in place to supervise and support staff was a performance appraisal system. However, the system had ceased in the previous year.

The person in charge said this decision had been made by the provider to allow the person in charge and staff to become accustomed to the change in management. The person in charge said she meets with staff informally and outlined her intention to recommence the formal system.

Staff rota:
There was no actual and planned staff rota for the centre. Timesheets were maintained for hours worked in the centre and staff signed in and out of the visitor's book on arrival to and departure from the centre. The person in charge said there was a fixed rota and that any changes were agreed with her prior to the change taking place.

Staff training:
A formal assessment of the required training for staff working in the centre had not taken place. The person in charge told the inspector that training in manual handling, occupational first aid, epilepsy which would include the administration of a medicine to be administered in the event of a medical emergency, and fire safety was required for all staff working in the centre.

The inspector viewed the training records and found that some staff had not received required training. Training had not been provided for some staff in the safeguarding residents and the prevention, detection and response to suspected or confirmed allegations of abuse, the management of behaviour that is challenging including de-escalation and intervention techniques and manual handling. In addition, none of the staff working in the centre had received training in occupational first aid and training in epilepsy to include the administration of a medicine to be administered in the event of a medical emergency.

Judgment:
Non Compliant - Major

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

Theme:
Use of Information

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

Findings:
The inspector reviewed the actions required from the previous inspection. Although some systems had been implemented to improve the recording practices in the centre, and thus ensure that staff had all necessary information to support residents, further improvement was required.

The policies required in Schedule 5 of the regulations were not available in the centre. Therefore the policies were not available to staff working in the centre. Staff were required to go to the administration building or contact the person in charge if they had any queries.

At the invitation of the person in charge the inspector visited the administration building to review policies and other documentation which were stored there. Although some policies were in place many of the policies were not in place or could not be found on the day. In addition, some policies which were centre specific to external organisations were in the folders in place of the centre policies.

Policies which were not in place included residents' personal property, personal finances and possessions; communication with residents; visitors; monitoring and documentation of nutritional intake; provision of information to residents; staff training and development; and recruitment, selection and Garda vetting of staff.

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:

Lorraine Egan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by BEAM Housing Association Ltd.
Centre ID:	OSV-0002067
Date of Inspection:	03 November 2016
Date of response:	13 January 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure contained inaccurate information, did not include an appeals procedure and did not include detail of the person nominated to ensure all complaints are responded to and records maintained.

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 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
The registered provider will update the comments, suggestions and complaints policy to include an appeals procedure and include the details of the person nominated to ensure all complaints are responded to and records maintained.
The register provider will remove HIQA from the list of authorities nominated to rectify complaints, as this is inaccurate information.
At a residents meeting on the 10th Nov 2016, residents received updated information on advocacy services.

Proposed Timescale: 31/01/2017

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:
One resident did not have a written agreement outlining the terms on which that resident shall reside in the designated centre.

Some information in the written agreements was inaccurate.

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

Please state the actions you have taken or are planning to take:
The registered provider will amend individual service agreements with regard to the complaints procedure and insert the new complaints appeal procedure.
The registered provider in the future will issue individual service agreements to new residents on admission to the designated centre.
The registered provider will issue an individual service agreement for the resident that does not have a service agreement in place.

Proposed Timescale: 31/01/2017

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:

A comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident was not carried out on an annual basis.

3. 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:
The person in charge will develop an intimate care policy in line with schedule 5 of the Health Act 2007.
The person in charge has developed an intimate care plan and this has been completed by each resident in November 2016. This plan will be reviewed annually or sooner if circumstances change.
The person in charge met with residents on the 14th November 2016 and each resident has been assigned a key worker to support them with their health and social care needs
The person in charge has given each resident a health assessment form. This form is being completed by the resident with the support of their family, their GP and the Key worker.
The person in charge has developed an epilepsy plan and this has been completed by both residents who have epilepsy with the support of their families.

Proposed Timescale: 05/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents' personal plans were not reviewed annually.

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

Please state the actions you have taken or are planning to take:
The residents had their PCP's updated in November and December 2016.
Residents have been assigned a key worker, goals have been identified and people have been assigned to support residents to achieve their goals.
PCP's will be reviewed annually and goals will be reviewed six monthly to track progress.

Proposed Timescale: 05/12/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An assistive rail in the bathroom contained rust.

There was no schedule to ensure the house was kept in a good state of repair on an ongoing basis, for example a 'deep clean' of the house or painting internally.

5. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The assistive rail in the bathroom has been replaced.
The registered provider has drawn up a rota for a deep clean of the designated centre in the communal areas.
Residents will continue to be supported by the staff to keep their rooms and the communal areas clean and tidy.
The stove is scheduled to be fitted in the sitting room by the 9th January 2017.
The registered provider will ensure that the painting and decorating needs of the designated centre will be listed in the maintenance log for the designated centre and followed up in a timely manner.
The registered provider will look at separating the heating system in 2017 for the designated centre, i.e. two control panels and two boilers.

Proposed Timescale: 30/04/2017

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 system outlined in the risk management policy for the assessment, management and ongoing review of risk was not adhered to.

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:
The registered provider will ensure that the risk management policy is updated.
The register provider will ensure that, the local risk register is complete and the assessment of risks is reviewed accordingly.

Proposed Timescale: 30/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements for maintaining all fire equipment were not ensuring that all equipment was serviced as required and all fire safety checks were carried out as required.

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

Please state the actions you have taken or are planning to take:
The registered provider has contacted the Service Contractor and they have agreed to complete all services on time within one week of the scheduled date of service due.
The person in charge and the staff team have reviewed the Fire Register and designed a template to ensure that all checks are carried out in line with the requirements of the fire register.

Proposed Timescale: 05/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The measures to ensure residents are aware of the procedure to be followed in the case of fire did not include fire drills to ensure residents were aware of the procedure to be followed at night.

8. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The residents and person in charge had a meeting on the 14th November 2016 to outline the plan and the necessity for participating in a night-time Fire drill.
The night-time fire drill was carried out on 25th November 2016 at 1.32am with the four residents present.
The registered provider will ensure that a night-time fire drill will be carried out every six months. The next night-time fire drill is scheduled for May 2017.

Proposed Timescale: 25/11/2016

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 in place in the designated centre did not ensure that the service provided was effectively monitored. **9. Action Required:** Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. **Please state the actions you have taken or are planning to take:** The registered provider is reviewing the staffing supports that are needed to manage the residential services effectively and provide the highest standards of quality and care. A new position will be created and advertised early 2017 to support the development of Residential Services going forward. The residents PCP's will be reviewed annually or more frequently if there is a change in circumstance. All risk assessments will be reviewed six monthly or more frequently if there has been a change in circumstances. The person in charge and the staff team will familiarise themselves with the Health Act 2007 and The National Standards for Residential Services. The person in charge will conduct regular staff meetings to ensure the highest standard of care.
Proposed Timescale: 31/03/2017
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** An unannounced visit to the designated centre had not been carried out at least once every six months. **10. Action Required:** Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. **Please state the actions you have taken or are planning to take:** The registered provider will carry out an unannounced inspection on the designated centre at least once every six months and put a plan in place to address any shortfalls in the quality and care of the service. We are currently working on a policy and template to conduct house audits on a six

month basis

Proposed Timescale: 20/02/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of the quality and safety of care and support in the designated centre had not taken place annually.

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

Please state the actions you have taken or are planning to take:
The registered provider will carry out an annual review of the quality and safety of care and support in the designated centre, using the annual review report template designed by HIQA.

Proposed Timescale: 20/02/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A planned and actual staff rota, showing staff on duty at any time during the day and night, was not in place.

12. 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:
The person in charge has drawn up a planned staff rota showing the staff on duty in the designated centre at any given time.
The person in charge will maintain the planned and actual staff rota.

Proposed Timescale: 25/11/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
Evidence of Garda vetting, references and a full employment history had not been obtained for all staff.

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

Please state the actions you have taken or are planning to take:
The person in charge has obtained Garda vetting for all staff.
The person in charge has obtained references for all staff.
The person in charge will ensure that schedule 2 of the Health Act 2007 is complete for every staff member working in the designated centre.

Proposed Timescale: 17/02/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The formal mechanism for ensuring staff were appropriately supervised had ceased in the year prior to the inspection.

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

Please state the actions you have taken or are planning to take:
The person in charge will carry out performance development reviews with staff in the designated centre on an annual basis or as per the staff's probationary period.

Proposed Timescale: 11/03/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A formal assessment of the required training for staff working in the centre had not taken place and staff had not received all required training.

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

Please state the actions you have taken or are planning to take:
The person in charge will ensure that all staff has access to appropriate training

including mandatory training and training to promote staff professional development. The following staff training will take place:
- Epilepsy & Buccal Midazolam training will take place on Wed 4th January 2017
- Safe administration of medication training will take place on the 5th & 6th Jan 2017
- PCP training will take place on Monday 23rd January 2017.
- Studio 111 training will take place on the 1st & 7th of February 2017
- First Aid Training will take place on the 15th, 16th & 17th February 2017
- Refresher First Aid training will take place on the 30th January 2017
- Manual Handling training will take place on the 28th January 2017
- Safeguarding Training will take place on the 25th January 2017
- Fire Safety Training will take place for members and staff on 22nd February 2017

The person in charge will review all training carried out in the centre and approve appropriate training for staff going forward.

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:
A number of 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 had not been prepared in writing, adopted and implemented.

16. 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:
The registered provider will prepare in writing, adopt and implement all of the policies and procedures as set out in Schedule 5 of the Health Act 2007.

Proposed Timescale: 30/06/2017