

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Laurels
Centre ID:	OSV-0003602
Centre county:	Dublin 5
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Michael Farrell
Lead inspector:	Karina O'Sullivan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
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: 08 May 2017 10:00 To: 08 May 2017 20:00

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

Outcome 01: Residents Rights, Dignity and Consultation
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 the third inspection of this designated centre. This inspection was 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.

How we gathered our evidence:

As part of the inspection, the inspector visited the designated centre, met with four residents and spoke with the person in charge and two staff members. The inspector viewed documentation such as, support plans, recording logs and policies and procedures. Over the course of this inspection, residents communicated in their own preferred manner with the inspector. Residents allowed the inspector to observe their daily life in the designated centre. This included meal times and activities. One resident identified " I like it here, and I go to meet my sister and go shopping for my clothes".

Description of the service:

This designated centre was operated by St Michael's House a company registered as a charity. St Michael's House is governed by a voluntary board of directors to whom

the CEO (chief executive officer) reports. This designated centre is based in Dublin 5. Five residents resided in the designated centre at the time of this inspection. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The inspector found the service provided was in line with the statement of purpose. The designated centre aimed to provide residential accommodation for male and female adults over the age of 18 with intellectual disabilities as outlined in the statement of purpose. The centre is situated beside another designated centre of similar design, they share the same person in charge and some staff. This centre was a six bedroom bungalow.

Overall judgments of our findings:

Nine outcomes were inspected against five outcomes were found to be moderately non-compliant. Four outcomes were found to be substantially compliant. Areas of improvement included, information contained within residents' files as well as the management of risk and medication.

The person in charge facilitated the inspection with the service manager and clinical nurse manager one.

All proposals outlined and plans agreed will be verified at the next inspection.

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 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 this outcome in relation to the non-compliances identified on the previous inspection and found the two actions remained outstanding.

The inspector viewed the complaints policy and procedure in place, however, the complaints procedure did not specify a nominated person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure all complaints were appropriately responded to and a record of all complaints maintained. The inspector was informed an individual was nominated within the organisation, however, this person also may be involved in the investigation process of some complaints.

The inspector viewed one complaint recorded within the centre's complaints log, grounds for concern were identified following a meeting completed with the complainant. The complaint records identified the complaint was upheld. Measures such as, manual handling refreshers were provided to staff members and guidance in relation to individuals needs were discussed with staff members. However, no records were maintained to identify if the complainant was informed of the outcome and their level of satisfaction with the measures implemented.

No other aspects of this outcome were inspected.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

The inspector found improvements were required in relation to residents' social plans to ensure the social goals set were reviewed in relation to the level of effectiveness.

The inspector viewed four residents' assessments of need, these included both social and healthcare assessments in eight areas. Areas included communication, social support, emotional wellbeing, general health, physical and intimate care support, safety, environment and rights. From these assessments an action plan was generated. This resulted in the development of various support plans. Residents' also had social goals completed within an "all about me" document. The inspector found the two documents were not linked and used as separate standalone documents.

The inspector viewed goals set, these included areas, such as, boat trips, musical shows, nights away from the centre and going to the cinema monthly. The inspector found there was no clear level of progression in areas identified nor did the review process identify the effectiveness of the goals set. However, from speaking with staff members and viewing other documentation such as, monthly activities evidence was available to demonstrate some residents achieved their goals. For example, pictures of boat trips and cinema tickets were available, however, for some goals which residents did not partake in there was no identification why these goals were not achieved.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The inspector found the designated centre was suitable and safe for the number and needs of residents. Improvements were required in relation to the risk management system, emergency lighting and sharp management.

There was certification and documentation to show the fire alarm, emergency lighting and fire equipment were serviced by an external company this was dated December 2016. Issues in relation to emergency lighting was identified within quarterly report as four lights were recorded as not working, these faults remained on the day of inspection. The person in charge had requested the maintenance department to repair these lights.

The designated centre had an organisational risk management policy in place, this included the specific risks identified in regulation 26. The designated centre had a risk register, which recorded a number of risks within the house and the controls in place to address these. These included areas such as, aggression and violence and self-harm. The inspector identified improvements were required to ensure the risk register reflected actual practice within the designated centre. Lone working occurred during each night when a member of staff attended to another centre to assist with personal care needs. Within this centre one resident was assessed as requiring three staff members to assist during the provision of intimate care needs. The inspector found this area of care provision was not accurately reflected on the risk register for periods when staffing levels were reduced.

The inspector also viewed individual resident's risk assessments in place these included areas such as, mobility. The inspector found improvements were required in some resident's risk assessments to include areas such as, epilepsy.

The inspector viewed a sharps container within the designated centre this was unlabelled with no tagging system in place.

There was a system in place within the designated centre to record accidents and incidents to ensure preventative measures could be implemented in order to mitigate reoccurrences.

The inspector viewed records of fire drills demonstrating all residents could safely evacuate the designated centre.

Residents had PEEP's (personal emergency evacuation plans) in place to assist staff to safely evacuate all residents.

The inspector viewed training records for four members of staff and all had received training in the area of fire.

The designated centre had a health and safety statement. The responsibilities of the various staff members within the organisation were outlined. The statement referenced a wide range of policies and procedures which supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as fire, adverse weather conditions, flooding and power failure.

The designated centre's vehicle was appropriately taxed, insured and had a national car test (NCT) certificate.

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:

The inspector found there were appropriate measures in place to protect residents from being harmed and to keep people safe. However, some improvements were required in relation to the management of behaviour support and restrictive practice.

The inspector viewed residents' behavioural support plans and other documents such as, positive mental health and emotional wellbeing support plans. The inspector found the documents identified both proactive and reactive strategies. However, some of the documents viewed did not clearly identify when medication could be administered to alter behaviours, for example, 'when anxious' was specified. The inspector found these documents did not guide staff members effectively and consistently in the area of care provision. The inspector identified the term 'anxious' to be interpreted differently by different members of staff this could negatively impact on the quality-of-life for residents.

The inspector found some environmental restrictions were in place such as a half door in the kitchen area, however, these were not managed in accordance with Schedule 3, as no record of restrictions was maintained. Other potential restrictions including a visual monitor and lab straps were in use, however, these were under review from the

restrictions committee.

The inspector found intimate care support plans were in place for various aspects of intimate care provision for residents requiring them.

The inspector found some staff members spoken with were unclear in relation to the reporting structure in place should an allegation of abuse arise. Residents spoken with were clear on what to do should they observe or experience poor aspects of service delivery.

The inspector viewed training records for eleven staff members of staff and found all staff members had received training in the area of adult protection and safeguarding training.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Each resident was supported to achieve the best possible health. However, improvements were required in the information contained in resident's healthcare plans and the review process.

The inspector viewed four residents' assessments of need, these included both social and healthcare assessments in eight areas. Areas included communication, social support, emotional wellbeing, general health, physical and intimate care support, safety, environment and rights. From these assessments an action plan was generated. This resulted in the development of various support plans. The inspector found some support plans were not related to the assessment, as the assessment identified there was no support plan required yet a support plan was developed. The inspector also found areas where the assessment identified a support plan was required but no support plan was developed. This was identified and discussed with the person in charge and the clinical nurse manager.

The details contained within some healthcare plans were not sufficient to guide staff members for example, in diabetic management. Two plans existed for the same condition, one plan identified interventions should the resident's blood sugars range fall

higher or lower than the recommended level and the second plan made no reference to this. Other supports plans did not specify the interventions taking place in practice, for example, monthly weights and sleep charts were completed, however, the support plan in place made no reference to this intervention. Therefore, some of the interventions in place were not reflective of practice and could lead to inconsistent care approaches. These interventions were not reviewed in relation to the effectiveness of the specific healthcare need. The inspector also found some of the support plans contained no information except refer staff members to another document, on viewing the other document this referred staff back to the support plan. These deficiencies within residents records did not ensure residents assessed needs were met.

Residents' also had a wellbeing meeting, this included collaboration from day services. Areas that required follow up within residents lives were identified during these meetings. On the day of inspection follow up of some of these items were not available such as, a scoliosis assessment in January 2017. The inspector requested the outcome of this, however, this was not available, nor had staff members knowledge of this on the day of inspection.

The inspector found access to required healthcare professionals required improvement, for example, one resident was awaiting a sensory assessment since the 05 November 2015. The inspector requested follow up, however, none was available within the designated centre.

Regarding food and nutrition the inspector found residents participating in mealtimes within the designated centre in accordance with residents' preferences in relation to food choices. Refreshments and snacks were available for residents outside within the designated centre.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

The inspector found the medication management system within the designated centre required significant improvement in relation to the management and administration of medication.

On the day of inspection, the inspector found some PRN medicine (a medicine only taken as the need arises) did not specify an expiry date.

The inspector also found some PRN medicine was not available within the designated centre.

No guidance was available in relation to the administration of some PRN medicine (a medicine only taken as the need arises). The inspector found staff members were not always guided effectively and consistently in the administration of medication. For example, residents were prescribed two medications for pain without guidance for staff on which to administer.

On the day of inspection, the inspector identified the keys for the medication press were not held securely. The inspector observed staff placing the keys in an unlocked key storage unit within the unlocked office. The inspector brought this to the attention of staff members.

The inspector viewed administration sheets and found the action from the previous inspection had been achieved as medication was administered as prescribed in relation to crushed medication. However, the inspector found some medications were administered from hand written pieces of paper stuck onto the administration sheet, this practice was not in line with the organisations policy.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. However, the inspector found this policy was not always adhered to within the designated centre.

The inspector crossed checked balances of some medication and found accurate records maintained.

Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received and a stock check was carried out once a week.

There was a system in place for recording, reporting errors and reviewing medication. The inspector viewed incidents which occurred within the designated centre and found preventative measure were put in place to mitigate the risk of future reoccurrences.

The inspector found the signature bank within the designated centre was completed.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Overall, the inspector found there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision and quality of the service delivered. Improvements were required to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

There was a number of audits completed within the designated centre. However, the management and oversight of medication, risk and staff supervision required improvement as identified in this report. The inspector also viewed an infection control audit conducted by a staff member from outside the designated centre. The inspector requested follow up on some of the items identified within the audit, while many had been completed, some remained outstanding.

Supervision was taking place, with associated performance development plans in place as required. However, it was noted that timelines were not identified in relation to performance plans.

There was an annual review of the quality and care completed in this designated centre dated December 2016.

There was a person nominated on behalf of the provider to carry out an unannounced visit on a six-monthly basis. This reviewed the safety and quality of care and support provided in the designated centre. The inspector viewed one completed in June 2016 and December 2016.

The person in charge had changed since the previous inspection. The inspector found the person in charge was suitably qualified, skilled and experienced, their role within the centre was a Clinical Nurse Manager 2 (CNM2) with authority, accountability and responsibility for the provision of the service. The person in charge was employed full-time, spending .5 of their time in the centre and the other .5 in the centre situated directly next door. From speaking with the person in charge at length over the course of the inspection it was evident they had knowledge of the individual needs and support requirements of each resident. Staff members spoken with highlighted how approachable and supportive this member of staff was. Throughout the course of the inspection, the inspector observed all residents knew the person in charge and were very comfortable interacting with them. The person in charge was supported in their role by a senior service manager.

The inspector viewed minutes of team meetings within the designated centre dated for

2016 and 2017. Areas discussed included policies relating to the designated centre health and safety and training in relation to person-centre care plans.

The person in charge met with the service manager to discuss areas relating to the designated centre and the inspector viewed minutes of these meetings. The service manager met with the representative of the provider to discuss service provision within the designated centre.

The person in charge informed the inspector they attended cluster meetings, this involved other designated centres within the same governance area of the service manager.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

The inspector found there was appropriate staff numbers and skill mix employed within the designated centre. Improvements were required in relation to the staff rota, staff supervision and staff training.

The inspector found the actual and planned rota was maintained within the designated centre. However, the coding system in place required improvement to ensure the planned and actual staff rota, identified all staff on duty at any time during the day and night was identified. One staff member was present in the centre next door during the night assisting in care provision, however, this was not identified within the rota.

The inspector viewed training records for four members of staff and two staff member required training in the area of diabetic management.

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):

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

Findings:

The inspector reviewed this outcome in relation to the non-compliances identified on the previous inspection.

The inspector found the Schedule 5 policies were present in the designated centre

- communication with residents
- visitors
- monitoring and documentation of nutritional intake
- provision of information to resident
- creation of, access to, retention of, maintenance of and destruction of records.

Over the course of the inspection, the inspector viewed the directory of residents and found this document did not contain all the information as specified in Schedule 3. The date of admission and the name and address of any authority, organisation or other body which arranged the resident's admission to the designated centre was not contained within the document.

Judgment:

Substantially Compliant

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:

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Michael's House
Centre ID:	OSV-0003602
Date of Inspection:	08 May 2017
Date of response:	14 July 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:

No record was maintained to identify that complainants were informed promptly of the outcome of their complaints or if they were satisfied with the outcome.

1. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed

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

promptly of the outcome of their complaints and details of the appeals process.

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

All complainants will be informed promptly of the outcome of their complaints and details of the appeals process, and this will be recorded.

Proposed Timescale: 31/05/2017

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:

Social plans viewed did not assess the effectiveness of each plan or take into account changes in circumstances and new developments for example, if goals set where not achieved.

2. Action Required:

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

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

- 1.The Goal Tracking template has been revised, and now includes a section for the recording of the effectiveness of the goal,
- 2.The Goal Tracking template has been revised, and now includes a section for the recording of any reasons why a specified goal has not been achieved.

Proposed Timescale: 10/07/2017

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 systems in place in the designated centre for the assessment, management and ongoing review of risk required improvement in relation to location and individual risks.

3. Action Required:

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

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

- 1.The Risk Register is in the process of review with the organisations H&S officer.

2. New Risk Assessments will be devised where required to ensure they reflect actual practice in this DC, including epilepsy and lone working.

Proposed Timescale: 31/08/2017

Theme: Effective Services

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

The sharps container within the designated centre was unlabelled with no tagging system in place.

4. Action Required:

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

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

The sharps container in place has tagging system in place and is clearly labelled.

Proposed Timescale: 10/07/2017

Theme: Effective Services

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

Issues in relation to emergency lighting was identified within each quarterly report, no evidence of follow up was evident in relation to areas identified.

5. Action Required:

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

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

The emergency lighting is now fixed. All follow up correspondence in relation to any identified issues is now emergency folder.

Proposed Timescale: 10/07/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some restrictive procedures were not applied in accordance with national policy and evidence based practice as restrictions were in place without clear guidance when these were to be implemented.

6. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

The environmental restriction which was sanctioned by the relevant committee has now been discontinued.

Proposed Timescale: 12/07/2017

Theme: Safe Services

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

Evidence that the least restrictive procedure, for the shortest duration of time necessary and that alternative measures are considered before a restrictive procedures were used was not evident within the designated centre and no record was maintained when restrictions were implemented.

7. Action Required:

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

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

1. Log for the use of environmental restriction is in use in this DC. All staff have been reminded of the requirements for recording same at the staff meeting on the 14th June 2017.

2. The environmental restriction which was sanctioned by the relevant committee has now been discontinued.

Proposed Timescale: 14/06/2017

Theme: Safe Services

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

All staff had receive training, however, some staff were unclear in relation to the reporting process.

8. 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:

Safeguarding process and staff requirements were discussed at a staff meeting on the 14th June 2017.

Proposed Timescale: 14/06/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Access to allied healthcare professionals was not timely, for example, one resident was waiting to see an occupational therapist since 05 November 2015.

9. 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:

- 1.All essential assessments are up to date and this resident is reviewed within required timeframes.
- 2.A Sensory Assessment review will be followed up and the PIC is exploring this with the OT department.

Proposed Timescale: 31/07/2017

Theme: Health and Development

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

Appropriate follow up to healthcare areas was not evident following wellbeing meetings.

Some support plans contained no information except to refer to another document, on viewing the other document this referred back to the support plan.

Some support plans were not based on the assessed needs of residents.

10. 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:

1. Following wellbeing meetings, where assessment results are retained in residents confidential clinical files off site of the DC, a note will be placed in the residents active DC file advising same.
2. Key workers will review all support plans to ensure the required information is contained within.
3. Requirements in relation to support plans were discussed at staff meeting dated 14th June for presentation and discussion at staff meeting in September.

Proposed Timescale: 22/09/2017

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:

Some PRN medicine did not specify an expiry date.

Some PRN medicine was not available within the designated centre.

No guidance was available in relation to the administration of some PRN medicine.

The keys for the medication press were not held securely.

Some medications were administered from hand written pieces of paper stuck on to the administration sheet.

The organisation's medication policy was not adhered to within the designated centre.

11. 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:

1. All PRN medication now have expiry dates.
2. All PRN medications are now in stock.
3. Signed protocols for all PRN medication have been developed and are available to guide staff. Discussed and circulated at staff meeting 14th June 2017.
4. Medication keys are now handed over from staff to staff at the beginning and the end of the shift.
5. All administration of medications is in line with the organisations policy on same.
6. Staff have been reminded about the requirements of this policy. Medication Management was discussed at the staff meeting 14th June 2017 and is on the agenda for all staff meetings.

Proposed Timescale: 14/06/2017

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:

The management systems in place in the designated centre required improvement to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

12. 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 HSE Nursing Metrics system is to be introduced into this DC as a support for the tracking and evidencing that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. The PIC is awaiting training on this system.

Proposed Timescale: 30/09/2017

Theme: Leadership, Governance and Management

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

Arrangements in place to support, develop and performance manage all members of the workforce exercise their personal and professional responsibility for the quality and safety of the services that they are delivering required improvement.

13. Action Required:

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

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

1. Staff Supervision and Support Policy for Staff working in Adult's and Children's Day, Residential and Respite Services in effect from May 2017.
2. All staff have been provided with a copy of this policy document and it will be discussed at the staff meeting scheduled on 14th June 2017
3. Support meetings have been scheduled and being held as per policy with all staff every 2 months.

Proposed Timescale: 14/06/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The planned and actual staff rota in place did not fully identify all staff on duty at any time during the day and night within the designated centre.

14. 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:

1. Roster review with HR conducted 12th June to ensure required staff in place
2. The planned and actual staff rota from the 22nd July will identify all staff on duty at any time during the day and night within the designated centre.

Proposed Timescale: 22/07/2017

Theme: Responsive Workforce

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

Two staff members required training in the area of diabetic management.

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:

1. Diabetes management training requested by PIC with NMOC 9th May 2017
2. Training will be scheduled to be completed for all staff by the end of September 2017.

Proposed Timescale: 30/09/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

Some of the information outlined in Schedule 3 was not contained within the directory of residents includes.

16. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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 Directory of Resident has been reviewed and is available in the DC.

Proposed Timescale: 13/07/2017