Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Our Lady's Centre
Centre ID:	OSV-0005450
Centre county:	Kilkenny
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Aileen Colley
Lead inspector:	Julie Pryce
Support inspector(s):	Gary Kiernan
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	9

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
17 August 2016 10:00	17 August 2016 20:00
07 September 2016 12:00	07 September 2016 19:30

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 06: Safe and suitable premises
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

Summary of findings from this inspection

This was a follow up inspection carried out to monitor compliance with the regulations and standards and to monitor the implementation of agreed actions from the previous inspection which was conducted on 4 May 2016, and at which there was found a high level of non-compliance with the regulations.

Following the permanent granting of an order under Section 64 of the Health Act 2007 the responsibility for operating this designated centre was transferred from St Patrick Centre (Kilkenny) Ltd to the Health Service Executive (HSE) in October 2015.

How we gathered our evidence:
This inspection was conducted over two days, the first day in the original on-campus locations and the second in a location where residents had been temporarily located in response to fire safety concerns. As part of the inspection, the inspectors spent time with seven residents. Inspectors observed residents going about their daily routines and were present when meals were being served on both days of inspection.

The inspectors also met staff members and managers including the person in charge. The inspectors observed practices and reviewed documentation such as personal

plans, medical records, accident logs, policies and procedures and investigation reports.

Description of the service:
The centre provided accommodation for 19 residents with intellectual disabilities over two sites. The first site which was visited on the first day of the inspection, was a series of campus based bungalows. The second site was a in a nearby temporary location to which residents had recently been relocated in response to safety concerns previously raised by HIQA.

Overall findings:
Inspectors found that a series of improvements had been made since the previous inspection and there was evidence of improved governance and oversight of the centre by the HSE.

However inspectors found that the premises in both locations were inadequate to meet the needs of residents. They also found that some residents had limited opportunities to participate in activities of interest to them or to engage with their local community.

The provider had not put adequate arrangements in place to safeguard residents as allegations of abuse had not been managed appropriately to ensure the on-going safety of all residents.

Improvements were identified in areas such as:

• improved social care and activities for residents (Outcome 5)
• risk identification and risk management (Outcome 7)
• safe management of medications (Outcome 12)
• continuity and consistency of staff (outcome 17)

The inspectors found that that found that further improvement was required in the following areas:

• residents' rights and their privacy and dignity not being promoted by staff on a daily basis (Outcome 1)
• the management of healthcare needs (outcome 11)
• investigation of allegations of abuse (Outcome 8 and 14)

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:
An agreed action relating to residents' privacy from the previous inspection had been addressed, but the inspectors were concerned that this had not translated into the privacy of all residents being respected.

For example, inspectors observed that personal and intimate care of residents could be observed from the staff room area. This issue was rectified during the course of the inspection by the addition of contact material to a window of a bathroom area. However, this had not been recognised by the service as an intrusion of privacy prior its identification by the inspectors.

Inspectors observed that there was an excessive amount of signage relating to staff practice in the homes of residents. For example there were prominent posters on some of the front doors at the entrance to the homes relating to the five moments of hand hygiene instructions. There was a staff notice board in one of the kitchens in the residents' home on which was displayed various staff notices, including a collection for a member of staff, and a social event, despite there being a staff office in the home.

There was a large red 'no smoking' sign in one of the kitchens which did not promote a homely environment. When further questioned by the inspectors staff felt that this would have to be referred to the health and safety committee, but could provide no further rationale for this sign in residents' home. There were also various notices including a list of phone numbers, safe handling principles and instructions for the tv, none of which the residents had the ability to read.

Inspectors on the previous inspection had concerns about bathroom privacy, and the agreed action was that thumb locks should be put on bathroom doors. This agreed action had not been implemented.

However, some progress had been made in relation to the communication needs of residents. Appropriate referrals had been made, for example to speech and language professionals and the introduction of the recommendations from such referrals were evident. For example there had been some progress made towards using objects of reference for residents.

On the second day of the inspection, in the other location where residents were being temporarily accommodated, the inspectors found rights restrictions relating to activities for residents. For example, activities for a resident who required the support of a staff member to administer rescue medication for epilepsy was curtailed because appropriately qualified staff were not always available. This is further discussed under outcome 5.

The inspectors noted that there was evidence of referrals to the service's human rights committee in relation to the rights of each person to both live in a community and not to be moved from their current home at short notice. This showed evidence of good practice.

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:
Some improvements had been made in the provision of meaningful activities, and in personal planning since the previous inspection. For example there was a clear improvement in outcomes for a resident identified as having unmet needs on the previous inspection. However improvements were still required in personal planning to

ensure that all relevant information was included.

Personal plans were in place for each resident, and these plans were structured and indexed so that information was easily retrievable.

Assessments had been completed on various aspects of physical and healthcare needs, for example in relation to swallow care and epilepsy. However, some significant pieces of information were not included, for example the personal plan for a resident with a visual impairment made no mention of this. In addition, there were no assessments of social care needs, or plans in relation to maximising residents' potential, as required by the regulations.

Personal plans included a person centred plan for residents, and goals had been identified for some. One resident had meaningful goals, which were broken down into smaller steps, however there was no evidence of achieving these goals, or of progress towards them. Another resident had goals relating to communication needs, but these steps had not been broken down, had not been reviewed within the required year, and the suggested communication passport had not been developed.

There was an improvement in the provision of activities for residents since the previous inspection. One resident who had been identified on the previous inspection as not having social needs met now had a schedule of activities, replaced equipment and was on an outing on the day of the inspection.

Activities had improved for other residents, and a record of all activities was kept. On the second day of the inspection, inspectors were shown a small activity room which had been set aside to meet the specific needs of a particular resident. However the activities for one resident were curtailed because of the requirement that they were accompanied by a staff member qualified to administer rescue medication for epilepsy, and that such a staff member was not always available.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
While the majority of residents were located in campus-based buildings, some residents were temporarily residing in an alternative setting in response to safety concerns.

The campus based facility comprised three bungalows each of which accommodated six, three and two residents respectively, and a further two interconnected single storey homes, accommodating a further eight residents. Each resident had their own room, and there were sufficient numbers of bathroom facilities available. Each of the bungalows had a kitchen dining area and adjacent sitting area.

Within the constraints of the current facilities inspectors observed that staff had made efforts towards ensuring that the bedrooms of residents were personalised, and that rooms had been set aside for the individual use of residents. For example an area had been set aside for the personal use of a resident to listen to music.

Inspectors were not satisfied that appropriate accommodation was provided for a resident with particular needs that were currently being met by the use of a modified room. There was no evidence that the actions taken following the previous inspection were meeting the needs of the resident. A hoist had been requisitioned and was seen by the inspectors. However it was situated at the end of a narrow corridor, and there was no evidence that it was actually in use. Staff engaged by the inspectors reported that they had not been trained in its use.

Inspectors observed that there were broken and unsafe toilets in two of the bathroom areas, and requested confirmation that these issues were dealt with immediately with photographic evidence of this. Photographs confirming that these issues had been addressed were received from the person in charge two days after the inspection.

The inspectors were assured that a housing profile for each resident had been developed, however there was no documentary evidence available at the time of the inspection. The inspectors requested that this documentation should be sent in to HIQA, but did not receive these documents as requested.

The second day of the inspection took place at the second temporary location of the designated centre. Seven residents were accommodated within the building, which had its own separate entrance.

There were two shared rooms which accommodated four residents, but inspectors were not satisfied that they were adequate to provide sufficient storage space for residents, or to maintain their dignity and privacy. In addition there was no evidence that residents had chosen to share rooms.

There was a small dining area for residents which had been converted from bedroom accommodation, and could only accommodate half of the residents. Another bedroom was in use as a small activity room, and there was a small sitting room available to residents.

The second alternative building, while comfortable, was not appropriate setting in which

to meet the long term needs of residents with disabilities.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
There was a system of recording accidents and incidents, including medication errors, however not all documentation had been fully completed. One of the records examined by the inspectors included both detail of the incident and a description of appropriate follow up. However, some of the incident records did not include this information. In addition the review of the record relating to a medication error did not include information to inform learning from the incident Accidents and incidents were reviewed at management meetings, and a record was kept of these meetings to inform learning.

A risk register was in place which included various risks such as choking, transport and behaviours of concern. This risk register included a list of centre specific risks in relation to the environment. Detailed risk assessments were in place in relation to individual risks to residents.

There was a personal evacuation plan in place for each resident and all fire equipment was appropriately serviced. Fire drills had been conducted at least twice a year, and in the first location of the inspection there was a system in place whereby staff from nearby centres on the campus were summoned to assist in an emergency. Records of the fire drills identified any areas which required follow up. A range of doors within the units at the first location of the inspection required replacement with fire doors, for example doors leading from corridors to bedrooms. However, the provider is giving consideration to alternative accommodation, and undertook to conduct a risk assessment in relation to postponing further works pending any moves.

A health and safety audit had been conducted which included areas such as escape routes, fire training and the testing of any portable appliances.

Judgment:
Substantially Compliant

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

Findings:
The inspectors were not satisfied that allegations of abuse had been managed appropriately.

There was insufficient evidence that allegations of abuse had been managed according to best practice. An investigation report relating to allegations submitted to the inspectors during the course of the inspection were not detailed, and inspectors requested further information to be submitted. Information was not initially submitted within the agreed timeframe, and inspectors again requested follow up information.

Further information was submitted to HIQA, but the inspectors were again not satisfied that this was adequate to ensure the safeguarding of residents, and were not satisfied that there was sufficient evidence to uphold the findings of the investigation. The record submitted did not provide sufficient evidence to support the findings. There was a further allegation which was outstanding and had not been investigated.

A review of the organisation's 'whistle blowing' policy dated 25 May 2015 was undertaken by the inspectors who were further concerned by the following phrase : 'It is expected that staff will raise issues internally rather than disclosing information to an external body ...' It was unclear that staff would be supported to raise concerns as required by the regulations.

The inspectors reviewed the behaviour support plan for a resident who was the subject of the allegations of abuse and found no reference to the management of the behaviours described in the allegations as requiring management. An agreed control measure following the allegations was that all staff should receive an update in training in relation to the protection of vulnerable adults, but inspectors could find no evidence of this having been implemented.

A further review of the management of behaviours that challenge was undertaken by the inspectors. There was insufficient evidence to support the use of restrictive interventions that were in place as follows:

There was a document relating to behaviour support for one resident which included some information relating to their assessment of needs, and a behaviour support plan dated January 2015. However, this document had several pages missing from the template in use, and referred to the use of 'as required' medication, with no further information as to the circumstances under which this medication should be administered, as further discussed under outcome 12. On further examination of the documentation the information was available in a different part of the resident's record, but the guidance for staff was not clear, and had not been reviewed within the year required by the regulations.

Guidance in another behaviour support plan for a resident directed staff to 'watch out for cues' but gave no information as to what the cues were.

Various restrictive practices were in place, but there was insufficient information in place to guide staff. For example doors were routinely internally locked so as to prevent residents from leaving, but there were no risk assessments to support this decision. During the inspection a resident was clearly indicating to an inspector that they would like to go out, by taking their arm and leading them to the door. Whilst staff immediately supported them to leave there was no record of this restriction and no report to HIQA that this was in place, as required by the regulations. Staff engaged by the inspectors could not identify any risk to this person related to their leaving the home.

A restrictive lap strap was utilised for one resident but there was no risk assessment or guidance document to direct staff in its use, and therefore no evidence of alternatives to the practice having been considered.

Intimate care plans were in place for residents. On day one of the inspection in the first location these plans were vague and did not include sufficient detail as to guide staff. On the second location on day two of the inspection intimate and personal care plans were detailed. In this location there was also a clear rational documented for restrictive interventions.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

implemented.

Findings:
Some improvements had been made in the management of healthcare since the last inspection, but not all the required areas for improvement had been resolved. Issues relating to institutional practices in the way that meals were prepared and offered had not been addressed.

While there were some systems in place to manage the healthcare needs of residents, improvements were required in the accuracy of guidance for staff, and in the management of healthcare issues previously identified by inspectors.

A health check assessment had been introduced, and had been conducted for all residents whose records were examined by the inspectors. Each resident had an annual health check conducted by their GP.

There were now healthcare plans in place for all aspects of healthcare examined by the inspector. Staff were knowledgeable about the needs of residents, and of the guidance in the plans. A sample of plans of care was examined by the inspectors and it was clear that improvements had been made in the information in the plans, and in the accessibility of the documents. Detailed plans of care were in place for various healthcare needs which included both the management of issues, and the prevention of recurrence. The information was clearly indexed, and easily retrievable.

However, some improvements were required in the detail of the plans of care. For example, the plan of care for a resident with mobility needs stated that they 'must be supported by staff to be more mobile'. There was no guidance as to what this meant, no recording of interventions and no baseline on which to base an assessment of 'more mobile'. The personal plan for another resident made no reference to their visual impairment.

There was a detailed plan of care relating to epilepsy for a resident, which included guidance relating to both the prevention and the management of the condition. However, the documented guidance for staff as to the actions to be taken when supporting a resident during a seizure was not in accordance with best practice.

The management of skin integrity had been highlighted on the previous inspection whereby inspectors were not satisfied that an appropriate referral had been made. Inspectors found a similar issue on this inspection. Staff reported that an email had been sent to the relevant healthcare professional, and a reply received to say that there were no concerns. However there was again no evidence of an appropriate referral or consultation.

However, other changing needs of residents were followed up appropriately, and residents and were regularly reviewed by their general practitioner (GP). There was an out-of-hours GP service in place.

Inspectors on the previous inspection found institutional practices regarding the preparation and serving of residents' meals. During this inspection there was no

evidence of any improvement. Residents' meals in both locations were prepared in a centralised kitchen away from the centre and brought to the unit in heated containers. Residents did not participate in the preparation of meals, and there was no evidence of the actions agreed following the previous inspection. Amongst those agreed actions was that food preparation would be built into person centred plans and times would be allocated to support residents to participate in the preparation of light meals and snacks in the centre. This had not been implemented.

There were records kept of referrals to healthcare professionals for residents in relation to their nutritional needs, including referrals to a dietician or speech and language therapist. Staff engaged by the inspectors were knowledgeable about the recommendations of these healthcare professionals, and could describe their implementation. Records of nutritional intake were kept for these residents. However there was no regular record of the nutritional intake of other residents as required by the regulations, other than occasional comments in the daily records, such as 'had a good supper'. These records were only commenced following a deterioration in a resident's condition.

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:
Prescriptions for regular medications contained all the required information including instructions for crushed medications, and had been reviewed appropriately. However, information in relation to 'as required' (p.r.n.) medication was not sufficient to guide decision making.

For example, protocols in relation to medication to relieve the potential cause of self injurious behaviour for one resident was not adequate, and the prescription for the administration of oxygen for another resident did not give any detail as to the circumstances under which it should be administered. The inspectors were concerned that this would lead to subjective and inconsistent decision making.

Medications were stored appropriately, and daily stock checks were undertaken. A monthly medication audit was conducted which included issues such as management of medication trolleys, dates of opened medications, and a stock check. However, as

discussed under outcome 14, the audit did not result in a clear action plan or any follow up to ensure appropriate improvements.

Judgment:
Substantially 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:
Although there had been improvements since the last inspection in the area of auditing, further progress was needed.

A suite of audits had been introduced, and audits had been conducted in health and safety and medication management. However the medication management audit did not result in a clear action plan against which to monitor the completion of required actions.

Six monthly unannounced visits had been conducted on behalf of the provider in both locations, and areas including rosters, personal plans and risk were examined during these visits. The resulting document included required actions and identified the person responsible for the actions. Some improvements had been made following these audits, for example the efficiency of recording of activities for residents had improved.

A person in charge had been recruited since the previous inspection and the inspectors found this person to be appropriately skilled, qualified and experienced to undertake the role.

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Judgment:
Substantially Compliant

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

Theme:
Responsive Workforce

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

Findings:
While staffing levels appeared to be adequate to meet the needs of residents, and were based on an assessment of need, improvements were required in the skill mix.

One of the residents required the support of a staff member qualified in the administration of rescue medication for epilepsy, but this was not always available. There was frequently only one nurse on duty who could not accompany the resident on outings, and no staff other than nurses were qualified to administer rescue medications. Under these circumstances the resident could not go out.

Staff training was up to date for the most part, however, training had not been provided in the administration of rescue medication for epilepsy as agreed following the previous inspection, and this was leading to negative outcomes for at least one resident.

Some improvements had been made towards ensuring continuity and consistency of staff. There was a bank of relief staff which were known to the residents. While unfamiliar staff were sometimes required, this was mostly for night duty, and there was always at least one familiar staff member on duty.

While a schedule of eight weekly supervision of staff had been developed, supervision had not yet taken place.

Staff engaged by the inspectors were knowledgeable about the needs of residents. Interactions observed were appropriate and respectful, and staff spoke fondly of residents.

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:

Julie Pryce
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 Health Service Executive
Centre ID:	OSV-0005450
Date of Inspection:	17 August 2016 and 07 September 2016
Date of response:	29 November 2016

Requirements

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

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

Outcome 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:** Residents' privacy was not maintained in bathroom areas. Excessive non person-centred signage did not promote respect for residents' dignity. **1. Action Required:** Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
• Visibility through the window is prevented through the use of darkened contact which was applied to the window on the day of the inspection. This will be replaced by a permanent solution such a frosted/tinted safety glass.
• Community Transition Coordinators have conducted an audit of aesthetics within the home environment. Each area will now receive a "make over" to create a homelier environment.
• All signage has been reviewed and changed/removed as appropriate.

Proposed Timescale: 31/12/2016

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:
Assessments omitted various areas of need for residents, and did not include an assessment of social care needs.

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

Please state the actions you have taken or are planning to take:
• A Social Care Team Leader is now assigned to the centre. She will oversee the implementation of social care assessments (using the Community Transition Toolkit) for each resident in conjunction with their assigned keyworker.
• Actions arising from a recent unannounced inspection from the registered provider will also be addressed as a matter of priority.

Proposed Timescale: 31/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Lack of goal setting did not support the maximising of residents' potential.

3. Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the

supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
• All personal support plans will be reviewed and updated to include residents personal outcome measures specifically identifying short, medium and long term achievable goals.

Proposed Timescale: 30/12/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises were not appropriate to meet the needs of residents.
The needs of residents were not met by the use of modified rooms.

4. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
• Case conferences with relevant personnel held on 19 September and 19 October in regard to alternative accommodation.
• Proposal provided to the registered provider and senior HSE staff on (28/10/16) for consideration regarding alteration to bedrooms with view to addressing the current environmental issues. Proposal consists of assessment of concerns, risk assessments and recommendations from Occupational Therapists Report.
• Further recommendations were made as result of a recent emergency situation.
• Plans to seek admission of a resident to another area has commenced.
• These plans discussed with HIQA over the phone on 14 November.
• Costing for structural modifications has been identified and funding is being sought.

Proposed Timescale: 30/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Bathroom areas were not in a good state of repair.

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:
• Extensive repainting has been undertaken in most of the living areas within the sector (kitchen/bedrooms/living area).
• Works to the toilets identified during the inspection as requiring repair/replacement have been completed.

Proposed Timescale: 30/11/2016

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:
Not all incidents were followed up appropriately.

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:
• Risk assessments are in place and are in the process of being reviewed and updated.
• Risk assessment workshops have been established and these provide weekly support and guidance to staff. These are conducted on an individual basis to upskill staff and instil confidence in proactive risk management.
• New Organisational Risk Management Policy has been forwarded to the HSE and the Quality Assurance Committee.
• All houses/homes have been issued with Reference Cards which set out in simple steps what actions staff should undertake in the event of a missing person, fire alarm, a safeguarding issue, etc. These Reference Cards will be developed further to include all possible situations and will be issued to all staff as a handy reference tool.
• Incident Report Writing is now part of the training calendar for all staff. This training coupled with regular audits of incident/accident reports and supervision by management will ensure incidents are recorded and followed up appropriately.
• A new system of recording and processing of medication errors has been introduced which includes information to inform learning from an incident.

Proposed Timescale: 31/12/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Restrictive interventions were not implemented in accordance with best practice.

7. 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:
• Risk assessments in place with regards to restrictive interventions and all will be reviewed and updated immediately and three monthly thereafter.
• Guidance will be issued for staff on the use of any restrictive interventions, the rationale for and the monitoring of same.
• Logs in place regarding lap belts on wheelchairs/comfort chairs and feeding chairs.
• New protocols for the administration of PRN medication to be introduced.

Proposed Timescale: 31/12/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The management of allegations of abuse was not robust.

8. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
• All allegations of abuse are dealt with in line with best practice. Internal Notifications, Preliminary Screenings, Trust In Care and/or Dignity at Work Investigations, Notifications to the regulatory body and the HSE and liaising with the HSE Safeguarding Team are all completed as appropriate.
• The Whistle Blowing Policy has been referred to the Quality Assurance Sub Committee for review.
• All Behaviour Support Plans will be reviewed to ensure they meet the needs of each individual. These plans will be monitored and regularly reviewed to ensure they are appropriate. Training in the Studio 3 approach to managing challenging behaviour will rolled out to all staff in the coming months.
• All restrictive practices within the centre will be reviewed and eliminated where possible. Any restrictive practices deemed necessary will be rigorously assessed to determine their appropriateness and referred to the Restrictive Practice Committee for approval.
• 59% of staff have attended the full Safeguarding Vulnerable Persons course. The remaining 35 staff will be attending the course on 02/12/16 and on the 27/01/17, 24/02/17 and 31/03/17 courses already scheduled.
Almost all of that 35 staff have already attended the Safeguarding Policy training on 16/02/16 and have attended the Safeguarding Workshop which was facilitated by a HSE

Safeguarding Officer on 11/11/16. Another Workshop is scheduled for 05/12/16.
• Weekly meetings have been arranged with designated officer, same commenced on 24th October to address this issue. Cases highlighted will be investigated individually to ensure the appropriate actions have taken place and safe guarding plans are implemented.
• Potential injury logs have been implemented in all areas. Designated officer continues to meet with groups of staff to educate further on safeguarding issues.

Proposed Timescale: 31/12/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Healthcare plans were not all adequate

9. 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:
• Baseline mobility assessments are now completed by staff for all residents and this will reflected in the risk assessments and care plans.
• Epilepsy care plans and Buccolam protocols are in the process of being updated to reflect GP guidelines and best practice.

Proposed Timescale: 31/12/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all appropriate referrals had been made.

10. 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:
• Medical files are in the process of being audited. Actions required from MDT referrals will be identified and reflected where appropriate.
• All referrals to allied health professionals will be made by completing the appropriate referral document, which will be discussed at the clinical review meetings monthly which in turn will direct the MDT. Clinical Reviews are ongoing with view to informing

pathways of care. MDT referral follow same.

Proposed Timescale: 30/12/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not involved in the preparation of their own meals

11. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
• While there are limited cooking facilities in most houses in the centre residents will be assisted by staff with the preparation of snacks and light meals which do not require cooking facilitates. The centre aims to cease all evening snacks/light meals being supplied centrally by the end of January 2017.

Proposed Timescale: 31/01/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inadequate records were kept of some residents'' nutritional intake

12. Action Required:
Under Regulation 18 (2) (b) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

Please state the actions you have taken or are planning to take:
• Nutritional intake will be monitored for 3 days to achieve a baseline for all residents. This will be reflected in the care plans by 30/11/16.
• Monthly or weekly weight recordings are taking place as directed by dietician.
• Any resident deemed to be under or over weight will have their plan of care amended accordingly.

Proposed Timescale: 30/11/2016

Outcome 12. Medication Management

Theme: Health and Development

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

in the following respect:
Guidance for the administration of p.r.n. medications did not include sufficient information to ensure safe administration.

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

Please state the actions you have taken or are planning to take:
• New PRN protocols are in the process of being introduced, PRN medication prescribed is in the process of being reviewed by nursing staff and the GP.
• New medication administration and management system in agreement with a community based pharmacy has commenced in one house in the centre and will be rolled out to all residents in the coming weeks.

Proposed Timescale: 31/01/2017

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:
Not all audits resulted in appropriate actions.

14. 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:
• Since September new CNM 2/ CNM1/ STL have been appointed, in process of actioning items previously highlighted by HIQA, registered provider and in house audits.
• Medication audits being completed weekly.
• Annual schedule of audits for the organisation has recently commenced.

Proposed Timescale: 30/12/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were not sufficient staff trained in the use of rescue medications for epilepsy to

meet the needs of residents.

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:
• PIC has liaised has with Training Coordinator regarding facilitating more courses for non-nursing staff to complete in relation to epilepsy and rescue medications.
• Medication Policy has been updated, signed by the Operations Manager and circulated. This reviewed policy allows for the safe administration of medication including emergency rescue medications by appropriately trained non-nursing staff.

Proposed Timescale: 30/03/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While a system of staff supervision had been proposed, it was not yet in place.

16. 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:
• Staff supervision meetings have commenced and schedule for all remaining staff is in place. These will be completed by the CNM2/CNM1s & Team Leader.

Proposed Timescale: 30/01/2017