Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Peamount Hospital Inc
Centre ID:	OSV-0003503
Centre county:	Co. Dublin
Email address:	ekeane@peamount.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Peamount Hospital Inc
Provider Nominee:	Robin Mullan
Lead inspector:	Linda Moore
Support inspector(s):	Deirdre Byrne; Noelene Dowling
Type of inspection	Announced
Number of residents on the date of inspection:	91
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 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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
17 June 2014 09:00	17 June 2014 19:45
18 June 2014 07:30	18 June 2014 16:45

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

Summary of findings from this inspection

This was an announced inspection of Peamount Healthcare Service on Campus to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. Inspectors visited the 15 locations within the designated centre where they met with residents and staff.

Inspectors observed practice and reviewed documentation such as personal care plans, medical records, accident and incident records, meeting minutes, policies and procedures, staff training records and staff files.

Overall, inspectors found that residents received a good quality service in the centre whereby staff supported and encouraged them to participate in the running of the house and to make choices about their lives. There were regular meetings for residents, and residents' communication support needs were met very effectively.

Appropriate governance arrangements were in place and inspectors found that the residents were comfortable and confident in telling them about their homes. While evidence of good practice was found across all outcomes, areas of non compliance with the Regulations were identified. Areas for improvement included risk management practices, sufficient staffing levels, fire safety and the documentation

available to support practices. The non compliances are discussed in the body of the report and included in the action plan at the end of this report.

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 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):
No actions were required from the previous inspection.

Findings:
Residents finances

At the time of inspection the provider was in the process of reviewing the policy to provide guidance to staff on the care of residents' property and finances, as required by the Regulations. However, this required improvement. While the provider and person in charge had put arrangements in place to protect the property and the finances of residents, these were not sufficient to ensure residents' finances were adequately protected and that there was transparency in relation to the use of residents' monies.

Resident's and their families made a contribution to the everyday costs of running the service. The amount was not set out in an agreement with the residents. Inspectors found that resident's monies were being used to purchase equipment such as beds, pictures and to pay for staff to accompany them on holidays, which contravened the policy and the Regulations.

No other aspect of this outcome was viewed.

Judgment:
Non Compliant - Minor

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

Theme:
Effective Services

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

Findings:
In general, inspectors found that resident's wellbeing and welfare was maintained by a high standard of evidence-based care and support. However, the documentation required improvement.
While residents had care plans and personal plans in place, the assessment and care plans were health focused and the personal plans did not include adequate information on residents specific social, emotional, participation needs, preferences and preferred routines. Improvements were required to ensure personal plans were outcome focussed rather than solely activity based. Some of the residents did not have goals defined in the plans and regular reviews of the plans were not taking place. There was a lack of evidence to show if the goals set in 2013 had been realised.
Inspectors found that there were frequent multi disciplinary meetings taking place to discuss residents needs, these meetings were documented.

While there were individualised risk assessments completed for some residents to ensure their continued safety, these were not consistently completed for residents at risk of choking, epilepsy and residents who resided without staff. See outcome eleven and seventeen.

Many of the residents had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Some of the residents attended a day service and others enjoyed a person centred service which was tailored to meet the needs of residents. Residents enjoy a number of social and therapeutic activities such as, shopping and day trips. There were many examples of where residents were supported to be independent and develop skills within the home or learn leisure skills. However, while there was some evidence of community involvement, Inspectors found that resident's opportunities to participate in meaningful community activities were being impeded by a lack of choice and/or inadequate supports. Residents told inspectors that they found the evening and weekend long and would like the opportunity to do more in the community.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors generally found that the provider had put sufficient risk management measures in place; however, they needed to be improved. For example, risks associated with fire safety. The systems for the identification, assessment and management of risk required improvement.

Inspectors saw evidence that the chief executive officer, person in charge, full time health and safety/risk manager and staff took responsibility for the identification of risks and ensuring that there were appropriate systems in place to manage risk. This included all risks associated with fire safety, residents at risk of choking and staffing arrangements. Staff had not received training in risk management.

Inspectors read the Health and Safety Statement for each location. This included many of the risks associated with the premises. The corporate and unit risk registers were reviewed as was the system of reporting risks to the management team. In addition, the health and safety/risk manager undertook a review of all incidents and accidents and the findings of this review were discussed with managers at the weekly management meetings and discussed at board level if required. An inspector reviewed minutes of these meetings which confirmed that actions had been taken as a result of the learning. For example, a learning outcome report was published to share any learning for the period.
All medication errors were reviewed weekly and changes made to the service as required.

While this was seen to be comprehensive, inspectors found that a number of the incident reports were incomplete and the staff did not have access to the necessary information following an incident to effect change.
Inspectors identified a number of risks during the inspection.

Inspectors noted that appropriate control measures were not in place to mitigate the risk to residents who resided in an unstaffed location close to the road, which may be accessible.

A domestic shower was provided in two locations which may be difficult for residents to

access safely.

See also fire safety issues below and choking risks in outcome 11.

The risk management policy was in draft format, while it included many of the aspects of the Regulations, it did not comprehensively include the practice in place for identification, recording, investigation and learning from serious incidents.

The inspector found that there was an emergency plan in place to guide staff in the event of such emergencies as power outages or flooding. All staff spoken with were knowledgeable of the plan. All management staff had received training on this plan. Improvements were required with regards to elements of fire safety. For example risks associated with the egress from two of the locations. Inspectors observed fire doors been held open with furniture during the inspection. There was evidence of regular fire drills and both staff and residents participated. Not all staff were able to tell inspectors about what they would do if the fire alarm went off. Records reviewed by inspectors indicated that fire training had been provided to all staff by e learning, however there was insufficient evidence to demonstrate that all staff had been trained in the use of fire extinguishers.

The records of fire drills were detailed and included learning outcomes. Fire equipment was serviced regularly, as were fire alarms and emergency lighting. Inspectors found that staff could not easily locate the keys to the door in one of the locations and staff were unable to safely move a resident from one of the bedrooms in the event of a fire. This was being addressed when it was raised during the inspection. While there were fire doors in many of the locations, these were not present in one of the locations, despite a report to the contrary. There were also cracks in the doors in this location, this would not prevent the spread of smoke in the event of a fire.

Personal evacuation plans had not been developed for residents, there were no risk assessments undertaken for the evacuation of residents who had reduced mobility and those who required a wheelchair to ensure their safety.
Inspectors were not satisfied with the arrangements in place to assess and control the risk to residents who smoke, while residents had smoking risk assessments in place, they were not comprehensive and did not include the actual area where the resident smoked. One resident may have placed themselves and others at risk due to the location of the smoking area. Residents care plans in this area did not guide practice.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. However there were areas for improvement.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. While inspectors were told and there was some records to show that almost all staff had received training on safeguarding vulnerable adults. The documentation was not maintained in a manner in which it could be ascertained that all staff had been provided with this training.

The policy on safeguarding residents from abuse contained guidelines on how any allegations of abuse would be managed. The provider had appointed a designated adult protection officer. The responsibilities for this person were contained in the policy, and the officer was a resource to staff should they need to discuss any concerns they had. Staff said they would also discuss issues with the person in charge who was knowledgeable in this area. A safety committee was established as required.

There was evidence that incidents of abuse were appropriately investigated and managed in accordance with the centres policy.

Throughout the inspection, inspectors noted that staff interacted with residents in a kind, caring, respectful and patient manner. Staff maintained resident's privacy during the delivery of intimate care.

Residents confirmed that they felt safe and described the staff as being very kind and were able to tell the inspector about a number of staff whom they could talk to if they had a concern.

Inspectors found from a review of a resident's records and discussions with staff, that one resident may not be maintained safely in the centre. While measures were in place to maintain the residents safely, the living arrangements for this resident required review.

Overall restrictive practices were used infrequently in the centre. A part time clinical

nurse specialist in behaviour was available to staff and residents. Inspectors found that the processes needed to be improved in line with the Regulations. While staff had been provided with training in the management of behaviours that challenge, this training did not include the use of restrictive practices. Residents had access to psychology and psychiatry services as required, however the evidence of these reviews were not demonstrated to inspectors. There was no documentary evidence to demonstrate who initiated the restrictive practice. There were no risk assessments in place to include the alternatives that were tried prior to its use.

There was no record maintained of the frequency of its use in all instances. The person in charge said that they were in the process of developing a positive approach committee to review any restraint in place. While residents had positive intervention support plans, some resident's plans did not guide the staff.

Inspectors read the restraint policy and the behaviours that challenge policy and noted that overall that the behaviours that challenge policy did not adequately guide practice. Staff stated they adhered to practices which were not included in the policy. There was no policy on use of restrictive procedures to guide practice.

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:
Inspectors found that while there were appropriate arrangements in place to support residents' health care issues as they arose. Inspectors reviewed the records for residents and found that they had access to a general practitioner, including an out of hour's service. There was evidence that residents accessed other health professionals in house and arrangements were made to other support services if required. Inspectors saw evidence of an annual review of residents by the GP for many of the residents, however these were not multidisciplinary in nature and did not include health action plans to guide the care.

One resident had moved location within the centre six months prior to the inspection; however the care plans were not updated to reflect the changes in the residents needs.

Inspectors found there was good practice in some areas, such as the falls prevention.

However there were aspects that required improvement. While resident's record stated that residents had unwitnessed falls resulting in a head injury, the neurological observations could not be located. There were no post falls assessment in place. There was no falls diary or any indication how many falls a resident had sustained, which would be useful information in planning the service for the residents. There was evidence to show that due to the interventions in place, such as low low beds, crash mats and reviews of medications, the number of falls for residents had decreased. Staff were very aware of the residents at risk of falls.

At the time of inspection three residents had pressure ulcers. These were appropriately managed and there were comprehensive plans of care in place.

There were policies on nutrition and hydration which supported evidence based practices. Inspectors found that the nursing staff monitored the nutritional status of residents, however this was not consistent for all residents, some residents were weighed three monthly, while others who had lost weight were weighed six monthly. Nutritional risk assessments were not consistently updated for residents at risk. Care plans were in place, however overall they did not guide practice. These needed to be further enhanced to include the recommendations of the speech and language and the guidance for staff in the management of residents who were overweight.

There were individual risk assessments completed for the use of bedrails, however they did not detail all of the risks associated with their use or the control measures. There were no records on the duration and release of the restraint. Inspectors found that many of the residents did not have a care plans to provide guidance to staff. One residents records did not demonstrate the appropriate rational for the use of bedrails in use, and this may have placed the resident at risk.

Inspectors found that while staff were knowledgeable on the care to be provided to residents at their end of life and residents had access to specialist palliative care services. Residents care plans did not include their preferences or wishes. A palliative care rooms was provided in one of the units which was appropriately equipped and facilitated relatives to stay with residents.

Residents received a varied and nutritious diet that was tailored to meet residents preferences and requirements. However, some improvement was required in the choice for residents. The dining experience required improvement.
The provision of modified consistency diets required improvement, staff could not tell the inspector what residents were eating on the day of the inspection. Residents who did not require a modified consistency diet were provided with potato and vegetables that were modified. The dining space in one of the units required improvement; there were two small dining areas. Resident's meals were going cold as they were stored in an open trolley when being transported to and waited in the second dining room.

There was insufficient space for all residents to sit at the table which made the dining experience disjointed. A number of the resident's wheelchairs did not fit under the tables. One resident was seated in a semi reclined position at the meal, this was addressed when the inspector raised this with staff. While snacks were available for residents, the choice of snacks for residents on a modified consistency diet was limited

due to access to the main kitchen in the evening.

Inspectors noted that the dining area in another location was not domestic in nature. While many of the residents said they enjoyed the foods, other said they would like more choice. Residents were not supported to prepare their own meals and told inspectors they would like this opportunity.

The advice from the dietician and speech and language therapist was clearly documented and staff were aware of residents needs, however the advice was not always followed. Inspectors were not satisfied with the management of residents at risk of choking in the centre. While there had been previous incidents of choking, appropriate risk assessments were not in place, care plans were not consistently in place to guide practice. Inspectors also noted that two residents who had choking incidents in 2014 resided in locations which did not have any staff on duty over night, despite both residents requiring supervision while eating. Another resident who had a recent choking event was provided with a list of "foods to be careful of". This would not guide practice.

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):
No actions were required from the previous inspection.

Findings:
Overall residents were protected by the centres policies and procedures in medication management. There were areas for improvement.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. Inspectors checked a sample of balances and found them to be correct.

Medication audits were completed to identify areas for improvement and there was documentary evidence to support this. Medication errors were appropriately managed and there was a system to review these incidents to minimise the risk of future occurrences. The pharmacist was involved in medication safety and review in the centre. All residents medications were reviewed three monthly. There were appropriate procedures for the handling and disposal of unused and out of date medicines. All staff nurses involved in the administration of medications had undertaken medication

management training. The administration practices in the centre were in line with best practices.

However, medication that required to be crushed had not been individually prescribed. The maximum dose of as required medication was not prescribed for all residents.

While there was a medication management policy in place, this did not include prescribing of medication and safeguarding. Residents who had epilepsy had a PRN protocol to guide practice in the event that they experience status epilepticus.
While the use of anti psychotic medications had been reduced and was reviewed regularly by the management team, inspectors found that there was no PRN protocol to guide staff in its use.

Nurses administered medication to residents, it was not the protocol within the campus for care assistants to administer medications. Inspectors found that this impacted on the quality of life of residents who could not leave the centre for more than one hour as there was not a nurse to administer medication in an emergency. Care assistants were also not knowledgeable of the resident's medication as it was seen as a clinical role.

Judgment:
Non Compliant - Minor

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:
The provider had undertaken a number of audits and reviews of the safety and quality of the service. Inspectors read the reports of audits undertaken in 2014 in the areas of meal times, care planning and hand hygiene. Residents were facilitated to communicate about the service through the house meetings, "speak up group" and suggestions made were taken on board. Residents are also included on the nutrition committee and provided feedback on the menu, for example. Inspectors noted that relatives attended the multidisciplinary team meetings on occasion and an open day was planned for the end of June where staff used the opportunity to meet with families.

While there were reviews being undertaken, these could be improved by including measurable outcome goals, where the benefits of improvements could be identified and verified.
The provider had established a management structure, and the roles of managers and staff were clearly set out and understood.

The structure included supports for the person in charge to assist her to deliver a good quality service. These supports included the assistant director of nursing and clinical nurse managers who reports to the senior management team and Board of Directors. The senior management team including the person in charge and provider met weekly.

There was a quality and risk committee in place, lead by the person in charge, a number of committees, including the drugs and therapeutics and human resources report to this committee. A report of all committees is reported to the board on a quarterly basis. The board report includes audits, policy development and staff issues.

Inspectors found that the person in charge was appropriately qualified and had continued her professional development. She had sufficient experience in supervision and management of the service. She was reasonably knowledgeable about the requirements of the Regulations and Standards, and had very clear knowledge about the needs of residents.

Inspectors observed that she had a person-centred approach with residents and staff through her open and friendly interaction with them. She demonstrated strong leadership and good communication with her team. She was an organised manager and all documentation requested by inspectors was readily available.
While there were deputising arrangements in place. Inspectors were not satisfied that the nurse manager on call at the weekend covered for the campus, older person services and the community services also had a caseload and was providing direct care to residents, therefore this may impact on the care provision and the supervision arrangements in the centre at this time.

Judgment:
Non Compliant - Minor

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:
While the staff observed to be very caring and passionate about the care they provided, inspectors were not satisfied that the staff number and skill mix was sufficient to meet the needs of residents. Inspectors found that while additional staff had been allocated in response to changing needs of individual residents, there were three locations within the campus where residents resided with no overnight staff. There was one resident at high risk of falls and another two residents at risk of choking in these locations, which may have placed them at risk. Staff described how they would pop in and out but the supervision arrangements of these residents were not robust. There were no risk assessments completed or control measures documented to mitigate the risk to residents.

Inspectors were not satisfied with the supervision arrangements in another of the areas on the morning of the inspection. The allocation of staff and supervision of residents required improvement. Residents who had high dependency needs were left unsupervised at times during the morning and staff concurred that this was the case on other days.

Staff files were reviewed and they contained all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Training records which had been held centrally outlined the training for all staff up until 2013. However as this had been devolved down to unit level in 2014, the system to demonstrate that all staff had received fire, manual handling and safeguarding training was not up to date. Many of the staff had received training in Dementia care and nutrition and Dysphagia training and training in the Regulations and National Standards in 2014.

Staff meetings took place regularly, however there was no formalised supervision of staff in place. While service level agreements were in place for agency staff, there was no evidence provided to the centre of the training provided to these staff or their experience in this area. An induction checklist was in place for agency staff, however this did not include fire training and was not signed by both of the staff members.

Inspectors found that volunteers were supported and supervised, they were vetted as per the requirements of the Regulations and the roles and responsibilities were set out in writing.

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:

Linda Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Peamount Hospital Inc
Centre ID:	OSV-0003503
Date of Inspection:	17 June 2014
Date of response:	08 July 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The management of residents finances required improvement.

Action Required:
Under Regulation 12 (4) (c) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the account is not used by the registered provider in connection with the carrying on or management of the designated centre.

Please state the actions you have taken or are planning to take:
Peamount's policy on supporting service users to manage their money will be reviewed and will aim to provide a clear and transparent process for service users, families and

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

staff. The contract for care will be amended to reflect the amount payable for services by each service user and to clearly state what services and facilities are included in this amount.

Proposed Timescale: 31/12/2014

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessments were not fully inclusive of resident's specific social, emotional, participation needs, preferences and preferred routines.

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

Please state the actions you have taken or are planning to take:
The documentation will be reviewed to ensure that it is appropriate and reflects an outcome based approach to supporting residents. A review of each individual's support plan will be undertaken with their circle of support and more appropriate goal setting will be prioritised.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of a robust system to assess the effectiveness of residents personal plans.

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:
All current support plans will be reviewed by the managers to ensure that they are reflective of the current support needs and are more outcome focussed for residents.

Proposed Timescale: 30/09/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal plan did not fully reflect the assessed needs of residents.

Action Required:
Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Proposed Timescale: 30/09/2014

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 risk management policy was in draft and did not meet the requirements of the Regulations.

Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The draft policy will be reviewed and amended to reflect the regulatory requirements and will be approved by management team and Board.

Proposed Timescale: 31/10/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system to assess and manage risk required improvement as outlined in outcome seven.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management

policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Training for staff on risk assessment will be delivered and staff will be supported to carry out more comprehensive risk assessments, at local level.
The risk manager will provide feedback to units on their own specific risk areas, on a monthly basis to ensure that learning from incidents is maximised and also that risks identified are managed appropriately.
A review of all smoking risk assessments will be undertaken to ensure that they are comprehensive, taking account of the resident's support needs and environmental issues.

A review by our fire consultants has been commissioned and we await their final report and recommendations. These will be addressed in order of priority.

Proposed Timescale: 31/12/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in fire safety as identified in outcome seven.

Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
An evacuation plan outlining each resident's method of evacuation will be developed by staff with the health and safety officer and will be displayed in each residence and brought to the attention of all staff supporting individuals in that house.

Proposed Timescale: 30/08/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were not knowledgeable of the fire procedures and there was insufficient evidence that staff had been trained in fire safety.

Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
Additional staff training will be delivered, including demonstrations on fire extinguishers. Training records will be updated to reflect all staff's compliance with annual fire training. Fire drills have been carried out in each area already this year.

Proposed Timescale: 30/09/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive procedures were not applied in accordance with evidenced based practice and the requirements of the Regulations.

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:
Peamount has approved a Human Rights Policy and is currently in the process of establishing a Human Rights/Restrictive Practices committee. Once established restrictive practices will be considered and reviewed by the committee to ensure best practice and clear guidance for practice.

Proposed Timescale: 30/09/2014

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident may not have been safeguarded.

Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
A multidisciplinary team is reviewing the living circumstances of an individual to ensure that she is safeguarded within that environment. Alternative accommodation, if required will be prioritised and ongoing review will be maintained.

Proposed Timescale: Ongoing

Proposed Timescale:

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:
The dining experience required improvement as outlined in outcome 11.

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

Please state the actions you have taken or are planning to take:
Capital funding has been requested to facilitate improvements to the dining room in one of the units. In the interim, staff have been supported to plan the dining experience so that food is not left out on trollies, residents are supported to eat their meals in a pleasant environment and all staff resources are used to assist residents where required, to minimise the risk of choking.

Units will be supplied with a range of nutritious and appropriate snacks for evening times and weekends and staff will be supported to store these appropriately at unit level when the main kitchen is closed. All dietary requirements can be catered for in this respect.
Joint Speech and language and dietetic guidelines will be reviewed and amended if necessary to ensure staff have clear guidance on foods to avoid and suitable foods for those residents who have particular swallowing difficulties.

Proposed Timescale: 30/09/2014

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:
The medication management policy did not guide practice.

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

Please state the actions you have taken or are planning to take:
A meeting with GPs was held on 4th July last and the GPs have been informed of the

requirement to specify individually all medications to be crushed and also the requirement to provide a maximum dose of all "as required/prn" medications.
A review of the restraint policy and "prn" protocols will be undertaken to ensure that it provides appropriate guidance for staff.
A number of non nursing staff have been trained in the safe administration of medication (SAM). We have secured training for a number of additional staff nurses as trainers to increase the numbers of staff trained onsite with the aim of enhancing quality of life for residents and minimising the impact of health needs on social opportunities.

Proposed Timescale: 29/07/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that the staff number and skill mix to meet the needs of residents.

Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Managers are aware of the need to prioritise high dependency residents. Indicators for quality care are very positive and reflect that care needs for this group are met. We aim, through a review of support plans and improved use of resources, to ensure that residents with high dependency needs have greater access to meaningful activities.

Proposed Timescale: 30/09/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of evidence to demonstrate adequate supervision of agency and existing staff.

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

Please state the actions you have taken or are planning to take:
The agency checklist will be re-circulated to all units and managers informed of the

need to use this form to orientate all agency staff. The agencies who supply staff to Peamount will be requested to provide evidence of all training and their recruitment processes for staff supplied.

The staffing levels in each unit will be reviewed in the context of service user support needs. If required, rosters will be revised to ensure that where risks associated with houses which are unstaffed are identified, that this can be addressed adequately. The CNMs will be given training and support to provide appropriate and regular feedback to all staff and to ensure that this feedback is recorded formally as part of a developing performance management system. We will implement fully the National Performance Management System once it has been rolled out.

Proposed Timescale: 30/09/2014