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 Catholic Institute for Deaf People
Centre ID:	OSV-0002090
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Catholic Institute for Deaf People
Provider Nominee:	Bernard McGlade
Lead inspector:	Linda Moore
Support inspector(s):	Deirdre Byrne;
Type of inspection	Announced
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	5

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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
05 August 2014 10:00	05 August 2014 18:00
06 August 2014 07:30	06 August 2014 18:20

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This registration monitoring inspection of St Joseph's House for Deaf and Deafblind Adults was announced and took place over two days. As part of the inspection, the inspector met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors received questionnaires from residents and relatives which were complimentary of the service being provided at the centre.

On the first day of inspection, inspectors found that there were a significant number of areas of non-compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (children and adults) with disabilities) Regulations 2013. In particular the provider and person in charge were required to take immediate action to address the following risks to residents:
・ Residents at risk of going missing
・ Poor management of smoking risk
・ Insufficient staff nurse levels
・ Chair lift was not working
・ Staff not trained in fire safety
・ There were no restrictors on the windows

These issues were discussed with the provider and person in charge and the restrictors were fitted and the chair lift were addressed prior to the end of the inspection.

On the second day of inspection, inspectors again found further areas of non-compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (children and adults) with disabilities) Regulations 2013 and in particular required the provider and person in charge to take immediate action to address the following risks to residents:
・ Healthcare needs of residents, such as falls prevention and management, nutrition, Dysphagia, epilepsy and diabetes were not being adequately managed to ensure the safety of residents
・ Risk issues associated with residents smoking, staff nurse levels and residents at risk of going missing had not been addressed.
Due to the number and seriousness of the findings the registration inspection was suspended. This was to enable the provider and person in charge address the significant healthcare risks, staffing and lack of clinical governance in the centre and which are detailed in this report .

An immediate action plan was issued to the provider on 7 August 2014.

Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

The person in charge and staff responded very effectively to the communication support needs of residents. Relevant information was available throughout the centre in accessible formats. Residents were consulted with about the running of the service.

Residents were supported by staff to pursue a variety of interests.

The staff were observed to be very caring and passionate about the care they provided.

Inspectors found that the provider and the person in charge had addressed four of the eleven actions that had been identified on the previous inspection.

These items are discussed in the body of the report and are 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:
Inspectors found that residents' rights, dignity and consultation were generally supported by the provider, person in charge and staff however, improvements were required in some aspects of dignity and privacy, the protection of residents' finances and the management of complaints.

The provider, person in charge and staff were committed to promoting the rights of residents. Residents told inspectors about their rights in the centre. They explained to inspectors that the staff understood their needs and treated them with respect. Residents gave numerous examples of how they were involved in the running of the centre for example clothes shopping. There were regular residents' committee meetings where residents made decisions and asked staff for support. While staff said that residents were involved in the development of their support plans, they were not able to tell inspectors about them.

Residents could make choices about their daily lives such as when to go to bed, what food to eat and how to spend their free time. Inspectors were concerned that some residents' had to access a shower in another part of the centres through the dining room which may compromise their privacy and dignity.

Staff were observed interacting with residents in a respectful manner, consulting with them and seeking their views.

Residents told the inspector about their involvement with their local community including trips to the supermarket, going out on day trips or home to visit family which they said they enjoyed.

At the time of inspection the provider had developed a policy on the care of residents' property and finances, as required by the Regulations. However this was not guiding practice. While the provider and person in charge had put arrangements in place to protect the property and the finances of residents, however there were not always signatures of the staff or resident maintained for each transaction.

Residents were supported and encouraged to take responsibility for personalising their own bedrooms. Inspectors saw lists of residents' possessions which were kept in the residents' files, and these were updated regularly to ensure that residents' property was accounted for and to prevent items going missing.

The centre had a complaints procedure but it did not meet all of the requirements of the Regulations. Relatives and residents who spoke with inspectors knew the procedure if they wished to make a complaint. Inspectors reviewed the complaints log and found that the records of complaints were not comprehensive, they did not include the detail of the investigation carried out, action taken and the satisfaction of the complainant. The complaints policy did not include the complaints officer, appeals process and the nominated person as per regulation 34.

There was an independent advocacy service available and the staff explained to inspectors examples of input from the independent advocate. However, residents were not aware of the availability of this service. There was no information in the centre on how to access the advocacy service. An interpreter service was provided as required to residents to ensure their needs could be communicated.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that the person in charge and staff responded very effectively to the communication support needs of residents. Relevant information was available throughout the centre in accessible formats. For example, a screen in the dining room

displayed the activity in the centre, including the menu for residents to view.

There was a Braille menu and library in the house for residents needs.

All staff had received or were in the process of receiving training in sign language to be able to communicate with residents.

While residents had a personal support plan, this was not available in an accessible format with pictures and photographs or in Braille to meet resident's needs. All individual communication needs were highlighted in the residents' personal plans.

The person in charge and staff had arranged regular meetings for residents in the centre as another way of supporting residents to communicate their views. Residents also told the inspector that they used the meetings to make decisions on what activities they wanted to engage in.

Residents told the inspector that they had access to magazines and TV with subtitles.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

Inspectors met with relatives who were visiting a family member and evidenced good rapport and communication between family members and staff. Residents told inspectors that family members and friends could visit at any time and some residents said that they visited their family home regularly.

Inspectors received completed questionnaires from some family members which were complementary of the service and opportunities being provided.

Both residents and staff confirmed that if they wished to meet a visitor in private, they could use the sitting rooms or their bedrooms.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
Inspectors found that the admissions policy set out the arrangements and guided practice regarding admitting new residents to the centre. This was also outlined in the statement of purpose.

Inspectors reviewed the contract of care and found that while it had been signed by the resident or relative, it did not include the services to be provided and the fees to be charged.

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:
In general inspectors found that residents had personal plans. However, some improvements were required to ensure personal plans were based on the assessed needs of residents and outline the supports required to maximise the resident's personal development in accordance with his or her wishes. The documentation in this regard was completed recently and was not comprehensive.

Each resident had a personal plan and inspectors reviewed many of the plans with a staff member. They were not based on the individual support needs of the resident and there was no documentary evidence of regular reviews. The personal plans were not multidisciplinary and there was no system to assess the effectiveness of the plans. There was no evidence of who was involved in the development of the plans.

The personal plans contained important information such as details of residents likes and dislikes, wishes and aspirations and information regarding residents' interests. There was some information on residents' specific social and preferred routines, however there was no comprehensive assessment of residents emotional, participation needs and preferences. There were individualised risk assessments in place but these were not detailed and would not ensure residents continued safety. See outcome seven and eleven for more detail. These had not been completed for residents who smoked or those at risk of going missing.

Residents had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. There was two activity staff in the centre. A number of residents also attended day services outside the centre. The centre had its own bus and driver and had access to a second bus during the summer months to facilitate trips. An Aromatherapist attended the centre for two days per week and residents said they enjoyed these sessions. A room was available for residents to enjoy these sessions in private.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The design and layout of the centre was not suitable to meet the needs of residents and did not meet the requirements of the Regulations.

All bedrooms were single and were appeared appropriate in size to meet residents' needs.

There were an insufficient number of showers and toilets in locations to meet residents' needs. As stated earlier in the report, residents had to go through the dining room to access the shower in another area of the centre.

One resident used a commode in the bedroom as there was no accessible bathroom within close proximity to the resident's bedroom.

There were no cleaners' rooms in the centre for the storage of cleaning equipment and chemicals. These were stored in laundry room and staff filed mop buckets from the sink in the laundry.

Inspectors spoke to domestic staff who were knowledgeable on cleaning processes in place, however the use of mops in the centre required review.

There was inadequate storage space. Inspectors observed residents equipment stored in residents bedrooms.

Inspectors noted that many of the residents had difficulty accessing rooms due to the lack of automatic doors and the number of ramps in the centre. One resident had a fall in 2014 due to the weight of one of the doors.

The centre was clean, comfortable, welcoming and well maintained both internally and externally. However there was no cleaning staff available in the afternoon to ensure that the premises would be maintained clean at this time. Staff and residents said the toilets could need to be cleaned and there were no staff available.

Inspectors found that the communal spaces and bedrooms were homely in design, decor and furnishings and this was also frequently mentioned by residents and their relatives.

Hand rails were provided in circulation areas.

A small passenger lift in addition to the chair life was provided. Inspectors found that the chair life was not functioning on the day of the inspection, it was subsequently repaired. The records showed this had been serviced in March 2013, however there was no system to ensure it was routinely serviced and checked.

The external grounds were well maintained.

The kitchen was found to be well equipped. Inspectors observed a plentiful supply of fresh food. Inspectors read the two recent environmental health officer reports and found that the actions identified were addressed.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors generally found that the provider had put some risk management measures in place however they needed to be significantly improved. Inspectors identified a number of risks in the centre which may have placed residents at risk. The risks associated with smoking, resident going missing, healthcare as per outcome 11 and staff nurse levels as per outcome 17 placed residents at significant risk. The provider was required to take immediate action to address these issues.

The systems for the identification, assessment, management, recording and investigation of risk required improvement.

Inspectors read the Health and Safety Statement for 2014 and the risk register. The risk register document was not centre specific and did not include risk assessments of the environment and work practices in the centre. The person in charge said this was provided to the centre the week before the inspection.

The person in charge and staff explained how they took responsibility for the identification of risks and ensuring that there were appropriate systems in place to manage risk. There were risk assessments completed but they were a poor standard and the control measures would not mitigate the risk of future occurrences. The staff told inspectors they were not sufficiently trained in risk assessment. This was confirmed from a review of the training records.

The risk management policy was not centre specific and did not meet the requirements of the Regulations. It did not include the actual practice for the identification and management of risk and the measures to control the risks.

Inspectors found that reasonable measures had not been taken to prevent accidents in the centre.

Inspectors noted that three residents had gone missing in 2014, while there were risk assessments completed, these would not control the risk and there were no care plans to guide the practice.

Inspectors noted that there were two residents with dementia who were at risk of wandering out of the premises. While one of these residents had a previous incident of leaving the centre, there were no control measures in place to reduce the risk of future occurrences. Inspectors noted that doors were open during the inspection. This was raised with the person in charge on the first day of the inspection and had not been addressed. There were no missing person profiles in place.

Inspectors found that there were a number of residents who smoked in the centre. There were no risk assessments or care plans in place to prevent an accident to these residents. This was raised with the person in charge but was not addressed. There was no risk assessment of the smoking room, however there were two smoking aprons available and there was evidence that the furniture used was fire retardant.

While all staff had received manual handling training, inspectors observed poor practice during the inspection, which could have resulted in injury to residents or staff. Manual handling assessments were in place, but they were not completed by staff that were competent in this area and were not sufficiently detailed to guide staff.

A number of accident and incidents for 2014 were being recorded and these were reviewed by the person in charge. However there was no evidence of the actions taken, for example, contacting the GP or the next of kin. While preventative measures were recorded, they were not robust. There was none or limited information in residents notes of the care provided to residents following an incident. There was a gap of nine days in one residents nursing notes following a fall which resulted in a fracture. There was some evidence that risks were being discussed at the management meetings, however there was no formal system to review or analyse incidents with a view to learning from them and reducing the risk of recurrence.

Overall fire safety was well managed. There were areas for improvement; all staff on night duty had not been provided with fire training. The person in charge said this was being addressed the day after the inspection. 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.

There was an emergency plan which identified what to do in the event of emergencies such as lost of power and heat. The plan included contingency arrangements for the evacuation of residents from the building in the event of an emergency.

Inspectors viewed the fire training records and found that not all staff had received up-to-date mandatory fire safety training and this was confirmed by staff. All staff spoken to knew what to do in the event of a fire and regular fire drills were carried out by staff at suitable intervals as defined by the Regulations.

Inspectors viewed the fire records which showed that fire equipment had been regularly serviced. The fire alarm had been serviced quarterly. Inspectors found that all internal fire exits were clear and unobstructed during the inspection. There was a robust system whereby staff checked fire exits daily and this was documented.

Written confirmation from a competent person that of all requirements of the statutory fire authority, was submitted to the Authority prior to the inspection.

Inspectors found that there were measures in place to control and prevent infection. Staff had access to supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available discretely throughout the centre.

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

Findings:
Inspectors found that measures were in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to allegations of elder abuse. A policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse.

All staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. A review of incidents since the previous inspection showed that appropriate action had been taken to respond to an allegation of abuse in the centre.

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

Overall restrictive practices were used infrequently in the centre. Inspectors noted that there had been a reduction in the use of bedrails since the previous inspection. There was a policy in place which would guide practice and residents were observed while using restraint.

There were a number of residents in the centre who displayed behaviours that were challenging. Staff had not been provided with training in the management of behaviours that challenge and told inspectors they were not sufficiently supported at times to manage this behaviour. While behaviour support plans were in place, they were not comprehensively completed; they did not include the triggers or the therapeutic interventions and therefore were not being implemented. There were no staff members in the centre with expertise in the development of these plans. 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.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
The person in charge was not fully aware of the legal requirement to notify the Chief Inspector regarding as per regulation 31. To date and to the knowledge of inspectors, all relevant incidents had not been notified to the Chief Inspector by the person in charge. The person in charge had not notified the Authority of three instances of unexplained absence of a resident from the designated centre.

While an allegation of misconduct was being managed by the person in charge and provider, this had not been notified to the Authority.

Judgment:
Non Compliant - Major

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
Inspectors found that residents' general welfare and development was being facilitated. Many of the residents attended a day service which provided a range of activities. Residents told inspectors that they enjoyed attending the day service as it gave them an opportunity to meet with their friends and chat with the staff who work there. Residents also told inspectors that they were supported by staff to pursue a variety of interests, including walking, bowling, swimming and attending the Dublin Deaf Club. Mass was held in the centre on a weekly basis by a priest with sign language. A hair dresser visited the centre on a weekly basis.

However, as stated previously, while residents were being supported to participate in activities, the personal plans were limited in scope and not based on outcome goals which included developmental goals such as training, education or work.

Judgment:
Non Compliant - Minor

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 were not satisfied that residents received appropriate healthcare to meet their assessed needs. The provider was required to take immediate action to address these risks.

Falls prevention and management:
There was no system in place to assess and manage falls. Records showed that some residents had repeated unwitnessed falls in 2014. Neurological observations were not completed following these falls. Resident's records did not demonstrate the care provided to residents following a fall. There was evidence that the GP had not been notified or reviewed each resident following a fall. Appropriate timely emergency care was not provided to one resident following a fall. There were no measures in place to minimise the risk of future falls, such as the use of hip protectors or increased supervision. While there were post falls assessments, these were not routinely completed. 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.

Wound care:
Wound charts had not been fully completed for residents with wounds. There were gaps in residents' documentation, one residents wound progress chart had not been updated since the 25 July 2014 and staff could not explain this to inspectors. Therefore it could not be ascertained if appropriate wound care was being delivered. There were no care plans to guide care, such as the frequency of the change of dressing or the type of dressing required. There was no evidence that the recommendations prescribed by the specialist in wound care had been followed. Care staff provided wound care at the weekends when there was no nurse in the centre. The care staff had not been provided with any training in aseptic technique or wound care. One resident's records showed that evidenced based nursing care had not been provided in the delivery of wound care, which may have placed this resident at risk. Staff were not knowledgeable on the use of pressure relieving equipment.

Epilepsy management:
Staff did not demonstrate competence in the management of residents with epilepsy. There was no policy or procedure to guide staff in the management of epilepsy. While there was an epilepsy management plan, it did not guide practice. There was no care plan or guidance for staff in relation to the management of this medical condition in caring for any resident during and after seizures, responding to any potential complications or for recording of epileptic activity to guide future interventions. When one resident had a seizure during the inspection, the nurse administered care. The care staff said they would not know how to respond to this event in the absence of the nurse.

Diabetes management:
One resident had a diabetes management plan which contradicted the resident's prescription and did not guide practice. Inspectors found that if this was followed it would result in poor outcomes to residents. Staff could not describe the care for this resident. The resident prescription could not be fully understood by all staff.

Dysphagia (swallowing difficulties):
There had been two incidents where residents had episodes of choking in 2014. There were no risk assessments or care plans to guide the care for these residents. Staff had not received training and were not competent in the management of residents with Dysphagia. Residents with swallowing difficulties were not provided with the altered consistency diets as prescribed by the speech and language therapist which placed these residents at risk.

Nutrition management:
Inspectors noted that there was a system in place to monitor residents' nutritional needs and weight. Residents' weights had been consistently recorded but there were no care plans in place to address identified weight loss. Records showed that some residents had varying levels of weight loss or unexpected weight gain. In discussion with the qualified staff she was unable to outline the care that was being delivered to these residents. The malnutrition assessment screening tools had been incorrectly completed. There was no evidence if residents who had lost weight had been reviewed by the GP as

planned. The chef was not competent in the fortification of residents meals for those who required a high calorie diet, therefore this was not been provided to residents. The chef could not tell inspectors which residents required a high calorie diet. The information provided to the chef was not reflective of all residents needs.

Catheter care:
Staff could not detail the care of residents with catheters insitu, there were no care plans to guide care. There was no information available on the type of catheter used and when this was due to be changed. Staff had not received training in this area.

Assessment and monitoring:
There was no follow through and monitoring of care issues and therapeutic blood levels of high risk medication. While a resident had bloods taken in April, there was no evidence of the results or any follow through by the nurses.

Another resident's records stated that stool samples should be taken but there was no evidence if this had been carried out or of any results.

While it was noted in the personal care book that some resident had bruises, there was no evidence of any analysis or follow through of the cause of the bruise.

Inspectors reviewed the records for residents and found that they had access to a general practitioner, including an out of hour's service. However while the GP provided advice to staff over the phone, there was not always a nurse present to assess residents. From discussion with care staff, review of resident medical and care files and evidence found, inspectors formed a view that care staff were not competent to assess, monitor and provide sufficient care to current needs of the residents. Training had not been provided and is further discussed under outcome seventeen.

Staff said that residents accessed other health professionals such as the physiotherapy, occupational therapist, dietician and speech and language therapist services if required. However there was a lack of documentary evidence that their recommendations had been followed.

There was some information on resident's health contained within the personal plans, However, these assessments did not include all aspects of the care required and as stated there were no plans in place to address the areas identified. While some of the residents had care plans, these had not been updated, were not accurate and did not reflect the current needs of residents.

For the most part residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff. Many of the staff ate with residents and there appeared to be positive interactions.

The chef served the residents in the dining room and received feedback on the food. There had been changes to the menu based on resident's feedback. Overall residents expressed satisfaction with the meal and meal times.

However, staff told inspectors that residents who required a modified consistency diet were provided with scrambled eggs most evening and if the resident refused the modified diet a normal diet was provided. Inspectors noted that specialised diets were not included on the menu. There was no evidence that this had been discussed with the residents GP or documented in the residents file.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Aspects of medication management including the safe administration of medication, and the competency of staff administering medication was not in accordance with professional guidelines and evidence based practice.

A policy on the management of medication was reviewed by inspectors. This policy did not guide practice, in the administration, transcribing medication, telephone orders, medication errors and withholding medication. The policy referred to the role of the nurse and did not reflect the practice on the centre of care assistants administering medications.

There was no policy on the use of PRN (as required medication), insulin or medication used for the management of status epilepticus. While inspectors were told that most staff had received training in the administration of medication, the records could not be located or were not dated. Medications were administered by untrained staff. Staff confirmed and training records substantiated that care staff administered medication to residents on day trips and had not received any training.

Inspectors found that some of these PRN medications were being administered on a routine basis rather than as PRN.

Inspectors found that staff who administered medications were not knowledgeable in the types of medications or the contraindications. Some of the staff had completed competency assessments in 2011 but had not received any update since then.

While there was a medication management protocol in place for residents who may experience status epilepticus. This did not guide practice. Care staff had also not received training in the administration of this medication. Therefore this medication could not be administered to one resident in the absence of the nurse.

Inspectors observed poor practice in the administration of medication, the nurse did not review the resident prescription prior to the administration of some medications.

Medications that required strict control measures (MDAs) were not managed in line with professional guidelines. The stock balance was not checked and signed at the change of each shift. While balances were correct, the count in the administration record was incorrect.

A medication audit had been completed by the pharmacist in August 2014, who identified also that the stock balance of the MDA's was not checked and signed at the change of each shift. There was no action plan in place to address this.

The records of medication errors could not be located during the inspection. The person in charge provided inspectors with the report of an error but this was not dated and the recommendations of retraining staff had not been completed.

Inspectors found that there was one resident's prescription for insulin which could not be clearly understood. The nurse was not able to tell inspectors what dose the resident had been prescribed for.

Inspectors found that residents medication was reviewed three monthly.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that the statement of purpose did not contain all of the information as required by the Regulations. The provider had made a copy available to residents. The complaints procedure did not meet the requirements of the Regulations. Inspectors found that the statement of purpose was not clearly demonstrated in practice. This did

not clearly describe the range of needs that the designated centre intended to meet.

Residents' needs varied from intellectual disability, mental health issues, dementia, old age and young residents with physical disability who are deaf and deafblind.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that the management systems in place did not ensure that services provided are safe, appropriate to residents needs, consistent and effectively monitored. The post of person in charge of the centre, was full time and met the requirements of the Regulations. The person in charge was supported by a care manager and the provider who reports to Chief Executive Officer.

The roles of nurse manager and care staff were not clearly set out and understood. Inspectors found that there was a lack of clinical governance in the centre which resulted in poor outcomes for residents. Inspectors identified non compliances in the areas of clinical leadership as outlined in Outcome 11, healthcare, risk management and insufficient staffing arrangements as outlined in Outcome 17.

While there was a clinical nurse manager in post, she was new to the centre. The care assistants were not supervised or supported at all times due to the absence of a nurse to meet residents needs.

While there was deputising arrangements in the absence of the person in charge, this was not sufficient to meet the clinical needs of residents in the absence of the clinical nurse manager. The on call arrangements at the weekends were provided by an agency nurse who worked part time in the centre.

Inspectors found that the provider had failed to ensure the arrangements provided sufficient oversight of key areas such as medication management, risk management and healthcare issues as discussed throughout this report.

A number of audits had been completed since the previous inspection. This included external audits of hygiene and infection control, catering services, the knowledge of the person in charge and care managers knowledge of the regulations. There was no system in place to review the safety and quality of care provided.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
There were suitable arrangements in the absence of the person in charge. See outcome 14.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
Inspectors found that the centre was not adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

There were insufficient numbers of nurses on duty to meet the assessed needs of residents. Inspectors found that while an assessment of staffing had been completed by the acting nurse manager, this would not be sufficient to meet the needs of residents and the plan had not been implemented.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
While the staff were observed to be very caring and passionate about the care they provided, inspectors found that the staff number and skill mix was not sufficient to meet the needs of residents. Inspectors noted that on a regular basis, there was no nurse on night duty or on a Sunday. Rosters were viewed by inspectors that showed that there was no nurse on duty from 13:00 on 04 August to 08:00 on 05 August 2014. There was no nurse on duty on 16, 19 and 20 July 2014. As demonstrated throughout the report, this was negatively affecting residents care needs.

Inspectors found that there were 12 residents with low dependency needs, five residents with medium dependency, 11 high and 11 maximum dependency needs.

There was an insufficient number of care staff on duty at the weekends to meet residents' needs. Rosters showed and residents and staff confirmed that there is a reduction in the number of care staff from seven to five at the weekend, despite any change in dependency and number of residents. Residents said that they often had to wait at the weekends due to the reduced number of staff.

While a staff member was allocated to the deafblind area from Monday to Saturday, this person was not allocated on a Sunday.

Staff files were reviewed and they did not fully contain 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. For example, there was only one reference for one staff member and this was not from a previous employer. There were gaps in a staff members curriculum vitae and these were not explained.

While there were no volunteers in the centre, files of external service providers were reviewed and did not meet the requirements of the Regulations. There was no Garda vetting in place.

There was no service level agreements in place for the agency staff, there was no evidence provided to the centre of the training provided to these staff or their experience in this area.

Inspectors read the individual performance reviews of staff and they appeared comprehensive.

Training records outlined the training for all staff. Records showed that mandatory training was provided to staff. Staff did not have access to appropriate training including refresher training in order to meet the assessed need of residents. Care assistants were required to make clinical decisions and provided clinical intervention such as the administration of as required medications and wound care and had not received training or guidance in this area. Staff had not received training in Dementia care, nutrition and Dysphagia training and epilepsy training to provide care to residents.

Judgment:
Non Compliant - Major

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

Theme:
Use of Information

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

Findings:
The provider and person in charge had ensured that residents were provided with a residents' guide. The residents' guide provided residents with information on the service, and included a section on how to make a complaint.

While all policies in line with Schedule 5 of the Regulations had been developed, these were not centre specific and did not guide staff in the delivery of services to residents and the running of the centre.

The registered provider had established a directory of residents. This contained almost all of the information as required by the Regulations. It did not include the name, address of any authority, organisation or other body which arranged the residents admission to the centre.

An inspector viewed an insurance certificate which confirmed that there was up to date insurance cover in the centre.

The provider was maintaining records in a secure and safe manner. Staff records were kept in a locked cabinet and residents' records were stored in a locked room in the staff office in the centre. Records were easily retrieved by inspector during the inspection.

However inspectors found that all records were not maintained in line with schedule 3. There were significant gaps in the nursing records and nursing records did not include all care provided to the resident, including a record of the residents condition and any treatment or other intervention. For example, one resident whose condition had deteriorated did not have nursing notes completed between 03/07/2014 and 14/07/2014 and from 24/06/14 and the 02/07/14.

Records were not maintained of any occasion where the resident refused treatment.

The records of medication errors or any adverse events in relation to residents were not maintained.

All referrals and follow up appointments in respect of the resident of the resident was not maintained.

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

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 Catholic Institute for Deaf People
Centre ID:	OSV-0002090
Date of Inspection:	5 August 2014
Date of response:	28 August 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.

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

Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Policy in relation to care of Residents Finance and Property is in place.
2. All Care Staff have now been instructed that receipts for Goods and Services for residents must be signed by resident to confirm agreement with expenditure.
3. If Resident is unable to sign, staff member must sign.
4. All withdrawals from Bank or Credit Union accounts will be signed by resident, additoin to Housekeeper and Director of Care..

ACTIONS TO BE TAKEN:
1. Follow up audit to be conducted to ensure compliance with the procedure. 30/9/2014
2. Finance (Ecternal Audit) to complete a six monthly audit. 28/2/2015.

Proposed Timescale: 20/9/2014 – 28/2/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not meet the requirements of the Regulations.

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

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Incident Report and Complaints Report have now been separated.
2. Complaint Officer has been appointed as from 26/8/2014.

ACTIONS TO BE TAKEN:
1. Revised Complaints Process to be put in place, including an appeals process. Will include details of independent advocacy service.
2. Offician Nominated Person (Advocate) Identified. Awaiting response for request to take up position.
3. Updated in-house poster and booklets relating to complaints to be displayed in residence by 12/9/2014.

Proposed Timescale: 12/09/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records of complaints did not include the details of the investigation carried out or the action taken in response to the complaint.

Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. The revised Complaints Reports now requires comprehensive record of complaint and detail of the investigation, actions taken and satisfaction of the complainant.

ACTIONS TO BE TAKEN:
1. Appeals Process will be referenced in the revised Complaints Policy.
2. Identification of the Nominated Person will be reverenced in the revised Complaints Policy.

Proposed Timescale: 28/08/2014

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of care did not include the details of the service to be provided and the fees to be charged.

Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Addendum for Contract of Care has been drafted.

ACTIONS TO BE TAKEN:
1. All Contracts of Care currently signed will have an addendum attached indicating additional services and costs.
2. These will be signed by the Resident / Their Relative by 18th September.

Proposed Timescale: 17/10/2014

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 personal plans were not multidisciplinary and there was no system to assess the effectiveness of the plans.

Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, 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:
ACTIONS TAKEN:
1 New Clinical Governance structure in place, including a Multi-Disciplinary Team, meeting monthly.

ACTIONS TO BE TAKEN:
1. Quarterly review of effectiveness of Care Plans by Care Manager, Keyworker, Resident and/or their representative.
2. The Multi-Disciplinary Team will review effectiveness of Personal Plans and make recommendations.
3. All Clinical Care Plans will be completed by 30th September.

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 progress of the plans had not been completed.

Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
1. Training to be provided for Keyworkers in three sessions ending 30/9/2014
2. The keyworker is to be given specific responsibility for completing progress updates on the Care Plans immediately following their training.
3. The Care Manager is responsible for managing and auditing this activity.

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 no comprehensive assessment of residents health, personal emotional, participation needs and preferences.

Action Required:
Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. A template has been completed for periodic review of Reisdent's Health.
2. A 'Health Management Plan' template has been designed to document mananagement of specific health issues.

ACTIONS TO BE TAKEN:
1. Each Personal plan will be updated to include a comprehensive assessment of residents emotional, participation needs and preferences.
2. This will be coordinated by the Care Manager in cooperation with the keyworker. Four plans per week to be completed per week to conclude 31/10/2014.

Proposed Timescale: 31/10/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an insufficient number of showers and toilets in locations to meet residents needs.

Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Distance from resident bedroom to the nearest bathroom complies with the regulations.

However….

ACTIONS TO BE TAKEN:
1. Resident is being offered a bedroom closer to a bathroom 5/9/2014.
2. Entrance to bathroom near Chapel to be re-constructed to enable the facility to be used in a safe manner by residents in wheelchairs. To be completed by 17/10/2014. This will mean that the resident no longer needs to go through the Dining Room.

Proposed Timescale: 17/10/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted that many of the residents had difficulty accessing rooms due to the number of ramps and the layout of the centre.

Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Door to Smoking Room re-adjusted to ensure it is not dangerous to residents.

ACTIONS TO BE TAKEN:
1. A review all ramps / doors as part of Risk Assessment. 26/9/2014
2. Further review by Multo Disciplinary Team. 15/10/2014

Proposed Timescale: 15/10/2014

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:
There was no system in place for the identification, assessment, recording and investigation of clinical and non clinical risk.

Inspectors identified risks in the following areas and there were no control measures in place to mitigate this risk:

Residents at risk of going missing

Smoking risks

Residents at risk of choking

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 Register System
ACTIONS TAKEN:
1. Two risk management assessors have been identified and have agreed to provide quotation
2. First weekly walk through on basis of current system completed

ACTIONS TO BE TAKEN:
1. Current risk register system, format and process to be reviewed and revised by 5th September
2. Selection of risk assessor to be completed by 29th August.
3. Top 10 clinical and non-clinical risks to be identified and assessed by 5th September.

Specific Identified risks

A. residents at risk of going missing
ACTIONS TAKEN:
1. High risk residents identified, concerned absence profile and management plans completed
2. All Care and Service staff informed of draft policy and procedures
3. Initial preventative measures implemented on perimeter exits, laundry door, main door and fire exits.
4. Alarm system for emergency doors has been upgraded to an addressible system.
5. Review of preventative measures by management walk through has been completed.

ACTIONS TO BE TAKEN:
1. More permanent solution for main door and exit from service yard to be in place by 5th September following environmental assessment.
2. Specialist Environmental Assessor scheduled to visit 27/8/2014..
3. Further actions will be undertaken based on report and recommendations of Environmental Assessor.
4. Electronic solutions identified. Selection and implementation by 5th September.
5. Policy to be ratified 12/9/2014
5. Training Sessions on policie and procedure to be held with all employees. 19/9/2014.

B. residents at risk from smoking
ACTIONS TAKEN:
1. Allocated room equipped with appropriate fire equipment
2. Risk assessments and smoking management plans in place for all residents who smoke.

3. Risk assessment has been completed on the Smoking Room. We are satisfied that all risks are minimised and controlled.

ACTIONS TO BE TAKEN:
1. Promotion of smoking cessation options to be implemented by multi-disciplinary care team on a three monthly review basis.

C. residents at risk of choking
ACTIONS TAKEN:
1. Residents at risk have been identified and reassessed under current format
2. Speech and Language Therapist assessments are fully up to date
3. Nurse manager informs kitchen and care staff of any SALT changes as they occur
4. Duty nurse meal checklist completed at each meal for each resident at risk of choking from 22nd August. Therefore, nurse ensures no deviation from SALT recommendations at each meal.
5. Nurse present at each meal time from 22nd August.

ACTIONS TO BE TAKEN:
1. Clinical governance review of current system to be completed by 5th September.
2. All care and kitchen staff to be trained in swallowing difficulties by 18th September.

Proposed Timescale: 19/09/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A staff member on night duty had not received fire training.

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:
Actions taken
Training completed with Staff member
New protocol in place for new staff members

Proposed Timescale: 14/08/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not been provided with training in the management of behaviours that challenge and told inspectors they were not sufficiently supported at times to manage this behaviour.

Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Specialist training scheduled for October 2nd, 9th, 16th

ACTIONS TO BE TAKEN:
1. Individual care plans for residents with behavioural issues will be completed by 30th October following specialist training.
2. Residents with Behaviours that Challenge will be reviewed at the Clinical Governance Meeting on 2/9/2014 with a view to putting an interim plan and/or training in place.

Proposed Timescale: 30/10/2014

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not notified the Authority of three instances of unexplained absence of a resident from the designated centre.

Action Required:
Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. New system for recording resident's unexplained absence now in place and the only occurrence since the inspection was reported immediately ot the Chief Inspector.
2. Significant actions have now been taken and are detailed in Outcome 7a of this report.
3. Following review of Restrictive Procedures Guidance from HIQA, there is a full understanding of reporting requirements ub /all future cases.

Proposed Timescale: 22/08/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While an allegation of misconduct was being managed by the person in charge and provider, this had not been notified to the Authority.

Action Required:
Under Regulation 31 (1) (g) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation of misconduct by the registered provider or by staff.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Disciplinary / Resident Abuse Allegations will now be reported to the chief inspector within three days of an allegation being made.

ACTIONS TO BE TAKEN:
1. Human Resources / Complaints Policy to be updated to reflect this requirement. 12/9/2014.

Proposed Timescale: 12/09/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate healthcare was not provided to residents in the areas such as:

Falls prevention and management:
There was no system in place to assess and manage falls. Records showed that some residents had repeated unwitnessed falls in 2014. Neurological observations were not completed following these falls. Resident's records did not demonstrate the care provided to residents following a fall. There was evidence that the GP had not been notified or reviewed each resident following a fall. Appropriate timely emergency care was not provided to one resident following a fall. There were no measures in place to minimise the risk of future falls, such as the use of hip protectors or increased supervision.

Wound care:
Wound charts had not been fully completed for residents with wounds. Therefore it could not be ascertained if appropriate wound care was being delivered. There were no care plans to guide care. There was no evidence that the recommendations prescribed by the specialist in wound care had been followed. Inspectors found that the care staff

provided wound care at the weekends when there was no nurse in the centre. The care staff had not been provided with any training in aseptic technique or wound care. One resident's records showed that evidenced based nursing care had not been provided in the delivery of wound care, which may have placed this resident at risk. Staff were not knowledgeable on the use of pressure relieving equipment.

Epilepsy management:
Staff did not demonstrate competence in the management of residents with epilepsy. There was no policy or procedure to guide staff in the management of epilepsy. While there was an epilepsy management plan, it did not guide practice. There was no care plan or guidance for staff in relation to the management of this medical condition in caring for any resident during and after seizures, responding to any potential complications or for recording of epileptic activity to guide future interventions. When one resident had a seizure during the inspection, the nurse administered care. The care staff said they would not know how to respond to this event in the absence of the nurse.

Diabetes management:
One resident had a diabetes management plan which contradicted the resident's prescription and did not guide practice. Inspectors found that if this was followed it would result in poor outcomes to residents. Staff could not describe the care for this resident. The resident prescription could not be fully understood by all staff.

Dysphagia (swallowing difficulties):
There had been two documented incidents where residents had episodes of choking in 2014, there were no risk assessments or care plans to guide the care for these residents. Staff had not received training and were not competent in the management of residents with Dysphagia. Residents with swallowing difficulties were not provided with the altered consistency diets as prescribed by the speech and language therapist which placed these residents at risk.

Nutrition management:
Inspectors noted that there was a system in place to monitor residents' nutritional needs and weight. Residents' weights had been consistently recorded but there were no care plans in place to address identified weight loss. Records showed that some residents had varying levels of weight loss. In discussion with the nurse she was unable to outline the care that was being delivered to these residents. The malnutrition assessment screening tools had been incorrectly completed. There was no evidence if residents who had lost weight had been reviewed by the GP as planned.

Catheter care:
Staff could not detail the care of residents with catheters insitu, there were no care plans to guide care. There was no information available on the type of catheter used and when this was due to be changed. Staff had not received training in this area.

Behaviour that is challenging:
There were a number of residents in the centre who displayed behaviours that were challenging. Staff had not been provided with training in the management of behaviours that challenge and told inspectors they were not sufficiently supported at times to

manage this behaviour. While behaviour support plans were in place, they were not comprehensively completed; they did not include the triggers or the therapeutic interventions to be implemented. There were no staff members in the centre with expertise in the development of these plans

Assessment and Monitoring :
There was no follow through and monitoring of care issues and therapeutic blood levels of high risk medication.
While a resident had bloods taken in April, there was no evidence of the results or any follow through by the nurses. Another resident had stool samples taken but there was no evidence of the results.
While it was noted in the personal care book that some resident had bruises, there was no evidence of any analysis or follow through of the cause of the bruise.

Poor manual handling practices observed

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:
A. Falls Prevention and Management
ACTIONS TAKEN
1. New falls risk assessment completed on all residents. New protocol in place for each category of falls risk (low/medium/high) giving a more accurate picture of our falls risks.
2. Formation of a falls prevention team completed
3. Physio, Pharmacy and OT confirmed as part of MDT
4. New protocols in situ for unwitnessed falls
5. Post falls assessment completed by nurse on duty after each fall.
6. Neurological observations carried out on all unwitnessed falls and as required on all remaining falls
7. All residents level of falls risk handed over to care team at shift handover to advise level of supervision required for each resident
8. All falls will be notified to GP by nurse on duty.

ACTIONS TO BE TAKEN:
1. Falls prevention to be agenda item at weekly monthly multi-disciplinary team meetings (Tuesday after doctors clinic). Note that the Clinical Governance Meeting, which meets on Tuesday, will become a MDT Meeting once per month. The GP is also being invited to this meeting.
2. MDT (Physio, Pharmacy and OT) to meet with falls prevention team to review all assessments, (completed) 29th August to minimise the risk of future falls
3. First Falls Protection Team Meeting 26/8/2014 as part of the Clinical Governance Meeting.

B. Wound Care
ACTIONS TAKEN:
1. Nurse Manager has completed wound care course and wound charts revised and

completed on each resident with a wound
2. All wound care intervention now carried out by the duty nurse including weekends

ACTIONS TO BE TAKEN:
1. All care staff to be trained on identification of threat to skin integrity and the use of pressure relieving equipment by 30th September by wound care specialist.
2. Full clinical care plans to be completed by 30th September with priority given to the areas of concern identified, as well as maximum dependency residents 29th August

C. Epilepsy Management
ACTIONS TAKEN:
1. Residents with epilepsy identified
2. Individualised epilepsy care plans in situ for the residents concerned and signed off by GP
3. Training by epilepsy specialist service completed for epilepsy management and administration of buccal midazalom for nurse manager and 6 care staff / medicators.
4. Draft policy in place for epilepsy management and protocol for administration of buccal midazalom currently being reviewed by epilepsy specialist service

ACTIONS TO BE TAKEN:
1. Training by epilepsy specialist service completed for epilepsy management and administration of buccal midazalom to be rolled out to additional staff including management team by 18th September.
2. Policy to be signed off by 29th August.
3. Review of care by MDT (neurologist, epileptic nurse) to be completed by nurse manager by 30th September.

D. Diabetes Management
ACTIONS TAKEN:
1. Residents with diabetes identified
2. Individualised diabetes care plans in situ for the residents concerned and signed off by GP
3. Clear protocol and prescription supplied by diabetes clinic in St Vincent's for insulin dependent diabetic
4. Identified and engaged dietician

ACTIONS TO BE TAKEN:
1. Full clinical care plans to be completed by 30th September with priority given to the areas of concern identified, as well as maximum dependency residents 29th August
2. Dietician to provide training for care staff of and residents with diabetes by 30th September.

E. Dysphagia
ACTIONS Taken
1. Residents at risk have been identified, reassessed under current format
2. Speech and Language Therapist assessments are fully up to date
3. Nurse manager informs kitchen and care staff of any SALT changes as they occur
4. Duty nurse meal checklist completed at each meal for each resident at risk of choking from 22nd August. Therefore, nurse ensures no deviation from SALT

recommendations at each meal.
5. Nurse present at each meal time from 22nd August.
6. Speech and Language Therapist has reviewed one resident as part of her schedule of ongoing reviews. Individual review schedules are in the Residents' Care Plan.

ACTIONS TO BE TAKEN:
1. Clinical governance review of current system to be completed by 5th September.
2. All care and kitchen staff to be trained in swallowing difficulties by 18th September.

F. Nutrition Management
ACTIONS TAKEN:
1. Identified and engaged dietician. Preliminary visit with Chef and Nurse occurred 11/8/2014
2. M.U.S.T. assessments completed on residents at risk
3. Weight management charts in place

ACTIONS TO BE TAKEN:
1. First audit of Kitchen, Diets and Menus planned for 8/9/2014.
2. Full clinical care plans to be completed by 30th September with priority given to the areas of concern identified. Plans for maximum dependency residents to be completed by 29th August
3. Dietician to identify residents at risk of poor nutrition and to develop individual care plans as appropriate
4. Specialist to provide training on nutritional supplements and provide tasting session for residents on nutritional supplements by 18th September.
5. One resident with specific (High Fat Diet) needs scheduled for private clinical review 28/8/2014.

G. Catheter Care
ACTIONS TAKEN:
1. Residents who require catheter care have been identified
2. Urology review scheduled for the catheter management for appropriate resident

ACTIONS TO BE TAKEN:
1. Full clinical care plans to be completed by 30th September with priority given to the areas of concern identified, as well as maximum dependency residents 29th August
2. Protocols and training for carers in the handling of catheters and catheter care to be completed by 29th August
3. Protocols for nurses for the changing and management of catheters to be in place by 29th August.

H. Behaviour that is challenging
ACTIONS TAKEN:
1. Specialist training scheduled for October 2nd, 9th, 16th

ACTIONS TO BE TAKEN:
1. Individual care plans for residents with behavioural issues will be completed by 30th October following specialist training.
2. Residents with Behaviours that Challenge will be reviewed at the Clinical Governance

Meeting on 2/9/2014 with a view to putting an interim plan and/or training in place.

I. Follow through on blood and other samples
ACTIONS TAKEN:
1. Tracking sheet in place for bloods and other samples taken for all residents to ensure follow up is complete on each sample
2. System now in place for prompt response for GP to review results and send back report

ACTIONS TO BE TAKEN:
1. Protocol to be developed by 18th September on the actions taken above

J. Record of unexplained bruises
ACTIONS TAKEN:
1. Specific care plan in place for the management of unexplained bruises.
2. New recording form designed, which becomes part of Resident's care plan as appropriate.

ACTIONS TO BE TAKEN:
1. Full Protocol to be developed by 18th September on the actions taken above. Supervisors and Care Staff to be trained by 25/9/2014.
2. Reports to be completed following observaitons by supervisors and/or care staff.
3. Investigation to be triggered on the basis of reports of >3 Bruises per month or Major Unexplained Bruise. Nurse Manager to report at Clinical Governance Meeting.

K. Poor Manual Handling Practices
ACTIONS TAKEN:
1. All manual handling assessments have been reassessed by nurse manage / manual handling instructor
2. 10 care staff trained in resident specific manual handling

ACTIONS TO BE TAKEN:
1. Remaining care staff to be trained in resident specific manual handling by 29th August.

Proposed Timescale: 30/09/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
High calorie diet were not been provided to residents as prescribed.

Many residents on modified diets were not receiving these as prescribed.

Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
ACTIONS TO BE TAKEN:
1. For residents requiring specific High Calorie or Modified Diets a weekly diet plan will be recorded in their personal plan as agreed with Nurse and Dietician.
2. Chef to be informed of specific needs on a weekly basis.
3. Care Staff in dining room to be aware of these requirements. All to be completed by 15/9/2014

Proposed Timescale: 15/09/2014

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:
Medications were administered by untrained staff.

Staff who administered medications were not competent in the types of medications or the contraindications.

Medications could not be administered to one resident as the care staff were not trained in the administration of this medication.

Medications that required strict control measures (MDAs) were not managed in line with professional guidelines. The stock balance was not checked and signed at the change of each shift.

Inspectors observed poor practice in the administration of medications.

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:
ACTIONS TAKEN:
1. New Clinical governance structure in place from 22nd August.
2. Certified care staff who administer medication to residents outside of the house do so only where approved by the nurse on duty, and with appropriate training and knowledge on how to safely administer mediation. Nurse will provide individual sealed medication parcels to Medicators pre-departure.

3. Refresher Medication Certificates have now been obtained and are on staff personnel files.
4. Care staff/Medicators completed refresher training on the 10 most commonly used drugs and pain management on August 14th.
5. 24 hour nurses will administer all medications and complete start and end of shift stock balance reports from 25th August.
6. Care staff to cease routine (morning, lunchtime, tea and night) administering of medication from 25th August.
7. Certification for care staff/Medicators will be refreshed by the pharmacy on Monday, August 25th.
8. Poly pharmacy specific training will take place 25th August for care staff/medicators.
9. From Monday 25th August, Clinical Nurse Manager will manage medication ordering, stock control, audit and medication errors in conjunction with pharmacy.
10. From 25th August, medication errors and incident reports will be separated and all medication errors will be overseen by the Nurse
ACTIONS TO BE TAKEN:
1. PRN Policy to be documented for consideration by Multi Disciplinary Team. 3/10/2014

Proposed Timescale: 03/10/2014

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:
ACTIONS TAKEN:
1. Medication Management Policy now under the admininstration fo Nurse Manager to ensure that policy guides practice.

ACTIONS TO BE TAKEN:
2. Medication Management Policy to be reviewed and updated. 19/9/2014

Proposed Timescale: 19/09/2014

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not meet the requirements of the Regulations and did not reflect the range of needs the centre intended to meet.

Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
ACTIONS TO BE TAKEN:
1. The Registered Provider will make appropriate changes to the Statement of Purpose, following consultation, on his return from vacation. To be completed by 15/9/2014.
2. The new 24X7 Nursing Arrangement will ensure that the range of needs identified in the Statement of Purpose can be supported.
3. The range of needs described in the Statement of Purpose will reflect the needs of the current residents. 15/9/2014.

Proposed Timescale: 15/09/2014

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place did not ensure that services provided are safe, appropriate to residents needs, consistent and effectively monitored.

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:
ACTIONS TAKEN:
1. Initial walk-through audit led by Chief Executive on 25/8/2014.

ACTIONS TO BE TAKEN:
1. The Registered Provider to select an Internal Safety and Quality of Care Audit group.
2. Training to be provided for the auditors selected. To be completed 30/10/2014.
3. Schedule of audits to be carried out to assess, evaluate and improve the provision of services. 7/11/2014

4. First Audit to be completed on 14/11/2014

Proposed Timescale: 14/11/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of clinical governance in the centre.

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:
ACTIONS TAKEN:
Our new clinical governance arrangement, in place from 22nd August is:
1. Nurse Manager reporting directly to Director of Care. (Contract amended to reflect new structure 25/8/2014).
2. Director of Care to attend weekly Clinical Governance Meeting with Care Manager. First Meeting 26th August.
3. All nurses report directly to Nurse Manager
4. New 24 hour nursing roster ensures Nurse Manager is responsible for clinical governance while nursing staff attend to day-to-day clinical needs.

ACTIONS TO BE TAKEN:
1.Clinical Nurse Manager reports daily via email to Director of Care commencing 25th August.
2. Monthly multi-disciplinary team meeting after Tuesday doctors clinic. Proposed for second Tuesday of the Month. Initial meeting on 29/8/2014 to agree protocols.
3. Clinical Care Plans are being prepared under the new clinical governance structure . Eight to be completed by 29/8/2014 for Maximum Dependency Residents. Six additional plans per week during the next month
4. Set agenda covering top 10 clinical risks for weekly meeting with GP to be in place by 9th September.
5. Written terms of reference and policy for clinical governance to be completed by 29th August.
6. Update Statement of Purpose to reflect new structure. Add to action list on 27/8/2014 meeting on HIQA Responses.

Proposed Timescale: 09/08/2014

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not adequately resourced to ensure the effective delivery of care and support to residents.

Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Revised Roster to ensure additional provision of care staff at weekends and meal times.
2. 24 X 7 Nursing now in place since 24/8/2014 under the supervision of the Nurse Manager.

ACTIONS TO BE TAKEN:
1. Continue recruitment drive for Nursing Staff.

Proposed Timescale: 06/09/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff files did not fully meet the requirements of the Regulations.

There was no service level agreements in place for the agency staff, there was no evidence provided to the centre of the training provided to these staff or their experience in this area

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

Please state the actions you have taken or are planning to take:
a. The staff files did not fully meet the requirements of the Regulations

ACTIONS TAKEN:
1. Additional Administration Support has been provided to the centre on a project basis to ensure that Staff Files fully meet the requirements of the regulations.
2. Review of all files to identify missing items. Approx 80% compliant.

ACTIONS TO BE TAKEN:
1. Action Plan required to manage this to completion by 30/9/2014.

Proposed Timescale: 30/09/2014

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an insufficient number of care staff on duty at the weekends to meet residents needs.

There was a lack of appropriate on call arrangements.

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:
ACTIONS TAKEN
1. The new Nurse Manager commenced employment on August 5th and completed induction training on August 22nd.
2. There is one additional care staff on duty at weekends for breakfast support (4 hours) and one additional care staff for Deafblind (6 hours per day) commencing 23rd/24th August.
3. From August 22nd, there is 24 hours nursing in place.

Proposed Timescale: 24/08/2014

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an insufficient number of nurses on duty at all times to meets residents assessed needs.

Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. 24 hour nursing is in place from August 22nd under the supervision of the Clinical Nurse Manager.

Proposed Timescale: 22/08/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have access to appropriate training including refresher training in order to meet the assessed needs of residents. Care assistants were required to make clinical decisions and provided clinical intervention such as the administration of as required medications and wound care and had not received training or guidance in this area.

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:
ACTIONS TAKEN:
1 Refresher training in falls prevention and resident specific manual handling has been completed with 10 care staff.

2. New training in epilepsy and buccal midazalon has been completed by 6 care staff.

3. 24 hour nursing is in place from August 22nd to ensure all clinical decisions and interventions are completed by qualified nurses.

ACTIONS TO BE TAKEN:
1. Remaining care staff to undergo training in falls prevention and resident specific manual handling by 29th August.
2. Epilepsy training and the administration of buccal midazalon to be undertaken by remaining care staff by 19/9/2014.

Proposed Timescale: 19/09/2014

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies in line with Schedule 5 of the Regulations were not centre specific and did not guide staff.

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with

Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
ACTIONS TAKEN:
1. Preliminary Review of policies that are in place to assess compliance with Schedule 5 and to ensure that they are centre specific.

ACTIONS TO BE TAKEN:
1. A Policy Team is to be established, on a project basis, to address issues raised.
2. Focus on revising the 21 required policies and procedures (Schedule 5) to ensure that they are centre specific during the month of October. 31/10/2014
3. Remaining policies to be reviewed and updated on a schedule to be provided. 31/1/2015.
4. As policies are reviewed and re-released, the staff are informed of their release, provided with access and trained in the key points.

Proposed Timescale: 31/01/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not meet the requirements of schedule 3 of the Regulations.

Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
ACTIONS TO BE TAKEN:
1. Register is being updated to include the referring body. Where a person has been present for a long tome it may be difficult to ascertain the referring authority or organisation. In these cases, the funder's detail will be provided. To be completed by 5/9/2014.

Proposed Timescale: 05/09/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents records were not maintained in line with schedule 3. There were significant gaps in the nursing records and nursing records did not include all care provided to the resident, including a record of the residents condition and any treatment or other

intervention. For example, one resident whose condition had deteriorated did not have nursing notes completed between 03/07/2014 and 14/07/2014 and from 24/06/14 and the 02/07/14.

Records were not maintained of any occasion where the resident refused treatment.

The records of medication errors or any adverse events in relation to residents were not maintained.

All referrals and follow up appointments in respect of the resident of the resident was not maintained.

Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
a. Significant gaps in records.

ACTIONS TAKEN:
1. New Clinical Governance regime in place – See undder Outcome 12.
2. Additiona Nurses hired, allowing the Nurse Manager(s) to concentrate on systems issues whilst safe nursing care is administrered day to day.
3. Review of systems currently used and improvements in the area of Periodic Health Check, Health Management Plans, Prolocols for Bloods, GP Checklist,
4. Review of assessments for residents with significant health needs.

ACTIONS TO BE TAKEN:
1. Handover from Care Supervisor to Nurse Manager on an agreed basis. 15/9/2014
2. Standard form to inculde 'Investigation' and 'Learning' sections. 15/9/2014

b. Records were not maintained of any occasion where the resident refused treatment

ACTIONS TAKEN:
1. 24 X 7 Nursing in place allowing for such records to be taken.

ACTIONS TO BE TAKEN:
1. GP to be informed in any case where a resident refuses medication / treatment. Will ask GP to provide guidance to the staff. 5/9/2014

c. The records of medication errors or any adverse events in relation to residents were not maintained.

ACTIONS TAKEN:
1. Medication Error Report Form has been procured from our Pharmacy.
2. Medication Error that occurred today (27/9/2014) has been recorded on this form.

ACTIONS TO BE TAKEN:
1. In the event of any Medication Errors, ths form will be completed
2. Log of all errors to be maintained 5/9/2014
3. Trends, Patterns and Learning to be discussed at Clinical Governance Meeting. 9/9/2014

d. All referrals and follow up appointments in respect of the resident was not maintained.

ACTIONS TAKEN:
1. Log of bloods taken and actions required is now being maintained.
2. Standard letter requiring follow ups on all medication and investigation procedures is being forwarded to GP on a weekly basis.

ACTIONS TO BE TAKEN:
1. Generate a log for Appointment / Referrals / Investigations / Tests.
- Numerical tracking system to be applied
- Dates for Appointment / Visit / Information or Report / Follow up.
- On completion of the process, evidence to be recorded in the Care Plan.
This action to commence on 1/9/2014.
2. Investigate the possibility of Nursing taking bloods and receiving results directly back to St. Joseph's House. 30/8/2014
3. Investigate Training Requirements for new nurses – TBC on Hire of Nurses.

Proposed Timescale: 01/09/2014