

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services South East
Centre ID:	OSV-0003277
Centre county:	Waterford
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services South East
Provider Nominee:	Johanna Cooney
Lead inspector:	Caroline Connelly
Support inspector(s):	Kieran Murphy
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
14 January 2015 13:00	14 January 2015 19:30
15 January 2015 08:30	15 January 2015 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was an inspection of a centre in the Comeragh services which is part of the Brothers of Charity South East. The Brothers of Charity South East provides a range of day, residential, and respite services in Waterford and South Tipperary. It is a not for profit organization and is run by a board of directors and delivers services as part of a service agreement with the HSE. During the inspection the inspectors met with residents, the person in charge, the regional services manager, the clinical Nurse Manager (CNM2), social care leader, a member of care staff, the psychologist, the social worker and other staff members.

Throughout the inspection the inspectors observed practices and reviewed documentation which included resident's records, policies and procedures in relation to the centre, medication management, complaints, health and safety documentation and staff files. The centre consists of one high support house that provides residential care to five residents with moderate to severe intellectual disability and multiple care needs. This centre operates on a full time basis.

The person in charge works full time and is the person in charge for five residential centres and also had responsibility for the Comeragh day services. He was seen to be involved in the organisation and management of the centre and was very knowledgeable of the residents and their needs. Staff and residents informed inspectors that the person in charge was accessible to residents, relatives and staff.

There was evidence of the staff supported and encouraged residents to maintain their independence where possible. There was a range of social activities available internal and external to the centre and residents were seen to positively engage in the social and community life. The inspectors observed evidence of good practice during the inspection and were satisfied that residents received a good standard of social and care and residents had appropriate access to their own general practitioner (GP), psychiatry, psychology, social worker and allied health professional services as required. However staffing levels required review to ensure full care could be given to residents with increasing dependency needs. Personal plans were viewed by the inspectors and were found to be generally appropriate to the needs of the residents and up to date.

Medication management practices were found to require significant improvements and a number of improvements were required in relation to the provision of evidenced based healthcare and in the development and updating of policies and procedures. Staff training, financial management documentation and health and safety also required improvement along with premises and accessibility for residents.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of 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. These areas include:

- medication management practices
- health and safety issues
- implementation of an appraisal system
- updating policies and procedures
- staff training and development
- provision of evidenced based practice
- review of staffing levels
- infection control practices
- improvements in documentation of financial records
- issues with premises and decoration of premises
- complaints

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors observed staff interaction with residents and noted staff promoted residents dignity while also being respectful when providing assistance. There was evidence that residents were consulted about how the centre was planned and run. On the first day of the inspection there was a residents' meeting that discussed items of interest for the residents and the plan for the following day including healthcare appointments. The inspectors were invited to and attended this meeting. The staff and residents confirmed this took place daily and on a weekly basis they had a planning meeting for the following week. This allowed residents to express their preferences around issues such as food choices and activities. Staff outlined that these meetings took place daily at the same time and each resident was invited to participate.

In Waterford Brothers of Charity there is an advocacy sub-group that is part of a regional advocacy team. This is a forum for residents to air their views to senior management about how services are delivered to them and to advocate both for individuals and groups of individuals about the services they receive. The service also employs a quality, training, development and advocacy manager who coordinates the advocacy services for the residents. An independent advocate was also available, if required, by residents.

There was a policy on human rights and a document on the procedures for the human rights committee. Neither of these documents had been updated since 2010. Inspectors saw that issues had been referred to the rights committee, for example in relation to the accessibility of the centre for people who used wheelchairs. It was specifically provided in the policy that any restrictions imposed on a resident as part of a behaviour support

plan had to be notified to the human rights committee. A recommendation from the rights committee was issued following a referral. Inspectors noted that it wasn't clearly set out in the policy document who the members of the committee were. Because the decisions of the committee impacted on a resident's life the fact that the members of the committee were not identified inspectors formed the view that this could negatively impact on residents' civil, political and legal rights.

The inspectors saw personalised living arrangements in residents' rooms with photographs, personal effects and furniture. There was adequate space for clothes and personal possessions in all bedrooms with adequate wardrobes and lockers. There were service guidelines available on the handling of personal assets with an up to date property list in each resident's personal folder.

There were two distinct processes to manage complaints. In the first instance there was a booklet issued in 2005 seen by the inspector with a process for when residents were unhappy with issues. The provider said this was updated in 2010. Each resident had a card with "I'm not happy" printed on it. This card, which also had the resident's name and picture on it, could be given to a staff member or put in a post-box for the social work department who reviewed each complaint. Once notified, the social worker would meet the resident who said "I'm not happy". The social worker would take the details of the issue and could meet with staff or other residents. A report with recommendations was issued by the social work department in response to the issue raised. Inspectors saw there were six "I'm not happy" issues for the centre for 2014, with three still being kept as open or unresolved.

The second complaints process was a more formal process. However the details of the complaints process were not displayed in a prominent position. The complaints policy did not identify the designated complaints officer and it also did not identify a nominated person with oversight of the complaints process to ensure that all complaints were appropriately responded to as required by regulation 34. The person in charge indicated that there was a complaints log available but staff spoken with by inspectors indicated that at a local level there wasn't a separate recording of complaints but they were recorded in each resident's personal folder.

Judgment:

Non Compliant - Moderate

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors viewed the admission policy which stated that residents were afforded choice and dignity through a holistic and person-centred approach to care and a welcoming and homelike environment was provided. The providers do not accept emergency admissions and all applications for admission to services are made to the director of services who passes them on to the enrolment team for assessment. The offer of any place is made in consultation with the HSE based on prioritisation. The person in charge informed inspectors that all prospective residents and their representatives were afforded an opportunity to visit the centre on numerous occasions and gradual stays were facilitated prior to admission. The criteria for admission was clearly stipulated in the statement of purpose and the person in charge informed the inspectors that consideration was always given to ensure that the needs and safety of the resident being admitted were considered along with the safety of other residents currently living in the centre. However the inspectors found that the admissions policy and procedures did not take account of the need to protect residents from abuse by their peers. The inspectors saw and were informed that due to exceptional circumstances there had been a resident transferred from another house into the centre without regular visits to the centre first. The person in charge said that regular visits to the centre would not have been appropriate for this resident. The inspectors formed the opinion that further consultation and consideration was required for the safety and needs of the residents currently living in the centre and the policy and practices required review to meet the requirements of legislation.

Inspectors reviewed copies of the current written agreements in relation to the terms and conditions of residents residing in the centre. They noted that the documents detailed the support, care and welfare of the resident and details of the services to be provided for that resident. The fees to be charged in relation to residents care and welfare in the designated centre were outlined as required by the regulations and the contracts also highlighted what was not included and extra to the fee.

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):

This was the centre's first inspection by the Authority.

Findings:

The service currently consists of a house in the community where five residents live. Inspectors were informed by staff that there were a number of options available for residents in relation to social activities. Some residents attended activities and day services while others participated in activities in the house. The inspectors saw that residents were supported to access and take part in social events and activities of their choices, which reflected the goals chosen as part of their personal plan. Residents to whom inspectors spoke described the many and varied activities they enjoyed and spoke of the day trips out and about dining out and going into town. Family involvement was encouraged with some residents visiting their family weekly others monthly.

The policy on human rights identified that the person centred planning process, with the personal outcome measures for each resident, provided the framework for the supports required by the resident. There were person centred planning guidelines available but these had not been revised since 2009.

The inspectors reviewed a selection of personal plans which were personalised and detailed resident's specific requirements in relation to their social care and activities that were meaningful to them. Each resident folder had a picture summary of the resident, together with their likes/dislikes and things that were important to them. There was a named key worker with responsibility to ensure each resident had a personalised plan. Other staff from day services and residential services also provided assistance with gathering information with the resident to inform the personal planning process. There was evidence of family input with family members being invited to a circle of support meeting to assist with planning the resident's goals for the year. There were agreed time-frames in relation to achieving identified objectives. In the sample annual plans reviewed by the inspectors issues discussed included sending greeting cards, going to a championship GAA match and referring issues to the human rights committee. Some action plans were found to be mainly task orientated and did not maximise the residents' personal development.

Inspectors saw that specific support plans were in place for residents identified needs. This included plans for issues like intimate care, nutrition support, medication support and mobility/positioning. There was evidence of input from relevant healthcare professionals in the development of these support plans. There was evidence of interdisciplinary team involvement in residents' care including, medical and General Practitioner (GP), speech and language, dentist and chiropody services. These will be discussed further in Outcome 11 healthcare needs.

Judgment:

Compliant

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):

This was the centre's first inspection by the Authority.

Findings:

The centre currently consisted of one house which provides accommodation in a detached bungalow setting. The communal accommodation comprises of a sitting room, a dining room/living room and kitchen. There were five bedrooms two of which had full en-suite facilities the other bedrooms had hand-washing facilities. There were adequate shower and bathroom facilities. There was a sixth bedroom that had been converted into a staff office. The house was bright and provided accommodation of a homely domestic nature. However the design of the house did not meet the needs of a number of the residents living there due to the presence of narrow corridors and narrow door frames. One resident has a specialised motorised wheelchair that he is unable to use to move around the house in, as the corridors and door frames are too narrow, therefore the resident is confined to the living room and the motorised wheelchair is used only as a lounge chair. This is taking away the residents independence and restricting his movements in accessing areas due to the poor design of the building. The inspectors saw another resident experiencing difficulties accessing the kitchen and dining room using his walking aid due to the narrow door frames and paint was noted to be off the door frame's due to numerous hitting off them with mobility aids as they are too narrow. The living room and other parts of the premises were also seen to be in need of redecoration due to paint off the walls.

Residents that showed inspectors their rooms stated that they were happy with their bedrooms and most had personalised their rooms with photographs of family and friends and personal memorabilia.

Laundry facilities were provided on site and were adequate. Staff said laundry is generally completed by staff but residents are encouraged to be involved in doing their own laundry. Residents to whom inspectors spoke were happy with the laundry system and confirmed that their own clothes were returned to them in good condition.

Equipment for use by residents or people who worked in the centre included wheelchairs, specialised chairs, hoists and other specialist equipment were generally in good working order and records seen by the inspectors showed that they were up-to-date for servicing of such equipment as most of the equipment was new.

The house was set in adequate grounds with car parking facilities and the gardens to the rear contained suitable garden seating and tables provided for residents use. Grounds were kept safe, tidy and attractive.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

There was a risk management policy and while it identified the hazard identification and incident reporting process it did not contain the measures and actions in place to control the following specified hazards:

- unexpected absence of a resident
- accidental injury
- aggression and violence
- self-harm.

There was an incident reporting process and each resident's personal folder contained the details of each incident. Inspectors were satisfied that all incidents were followed up appropriately with recommendations being put in place to prevent the accident happening again. There was a risk register for the centre which outlined assessments undertaken for issues like:

- electricity
- slips
- chemicals
- fire
- manual handling
- cleaning
- access to medication
- challenging behaviour
- volunteers

Each issue on the risk register included an analysis of whether the issue was a high, medium or low risk and also identified the controls in place to manage the issue. Linked to the risk register each resident had risk assessment and management plans in place. Issues identified included wheelchair accessibility for one resident and walks in the local community for another resident. However not all issues identified on the risk register had been completed fully with a number of assessments not identifying if the issue was

a high, medium or low risk. Inspectors reviewed a safety audit which staff had completed in September 2014. The actions from this audit included modifying the doorways to provide for wheelchair accessibility.

There was an emergency evacuation plan dated October 2014 which identified the arrangements in place to respond to emergencies like fire, adverse weather conditions, outbreak of an epidemic, loss of power and loss of heating. In the sample healthcare files seen by the inspector each resident had a personal emergency evacuation plan which included procedures for evacuation during the day and separate procedures for evacuation at night. Records indicated that four evacuation drills had taken place in 2014 including one at night.

There was a policy on transport and use of transport vehicles and inspectors saw evidence that the vehicles were roadworthy, regularly serviced and insured.

The inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:

- Servicing of fire alarm system and alarm panel
- fire extinguisher servicing and inspection May 2014
- records of daily inspection of means of escape routes
- records of monthly inspection of emergency lighting.

Not all staff had been trained in fire safety within the last year and some had not received fire training since 2011. All residents spoken with knew what to do in the event of a fire, including the evacuation routes and assembly points. A consulting engineer's report from April 2014 seen by inspectors had a number of recommendations including that there should be a new cross hallway fire door. The person in charge outlined that structurally this could be completed but would restrict the accessibility of the house for residents.

The inspector viewed training records which showed that staff had received up to date training in moving and handling. A number of the residents were not independent with mobility and hoists and other equipment were used so this training is essential to ensure staff provide care in accordance with evidence based practice.

There were guidelines in relation to control and prevention of infection and the centre was visibly clean. There were cleaning schedules in place and staff spoken with were aware of infection control principles. In relation to laundry residents brought their clothes for washing to the utility room. Staff outlined water soluble bags were not available for any items that were soiled. There wasn't any separate waste disposal for clinical waste. A food bin was observed on the counter top in the kitchen which was directly beneath the hand towels for drying hands, these practices were non in line with infection prevention standards.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

This was the centre's first inspection by the Authority.

Findings:

Policies and procedures were in place for the prevention, detection and response to abuse however these were dated 2009 and required review. Staff with whom inspectors spoke knew what constituted abuse and they demonstrated an awareness of what to do if an allegation of abuse was made to them. There was a guidance statement for the welfare and protection of vulnerable adults, dated 2011. It outlined the procedures to be followed in relation to an allegation of abuse against a staff member, against a person with responsibility for the service, against a volunteer and against another person with an intellectual disability. While the senior social worker was the designated person to respond to an allegation of abuse, he wasn't specifically referenced in the policy as the designated person either by name or by job title. The senior social worker outlined to inspectors the process for managing resident protection concerns. Each allegation was referred to management and monitoring team who undertook a formal review of the allegation. The outcome of the review is discussed at the management team meeting and was put in report format by the social worker. Each report from social work was discussed at a management level by the provider, the person in charge with representation from the psychology department and the psychiatry service.

The training department coordinated training on allegations of abuse, which is delivered by the social worker and records showed that all staff had attended. However records confirmed that some staff had received this training in 2009 and had not had refresher training.

Residents to whom inspectors spoke confirmed that they felt safe. Inspectors noted a positive, respectful and homely atmosphere and saw that there was easy dialogue between residents in their interactions with staff.

Inspectors reviewed the local arrangements' to ensure residents' financial arrangements were safeguarded through appropriate practices and record keeping. There were guidelines in place which included guidance on the completion of money management competency and inspectors saw evidence of these completed in individual residents' files. The centre has also updated its policy and practice in relation to maintaining an asset register. The staff informed the inspectors that all financial transactions were

possible; were signed by residents. In addition transactions were also generally checked and signed by staff and written receipts retained for all purchases made on residents' behalf. However, inspectors saw that there were not resident signatures for a large number of transactions. The finance policy stated that a maximum amount of money should only be kept in cash in the house for each resident. However, staff were not following the policy as to the inspectors saw that money kept for each resident exceeded this amount. Bank statements regarding finances were issued directly to residents. Inspectors saw residents finances were subject to checks by staff which included internal and external audit. But overall the inspectors found the system of management of resident's finances was not sufficiently robust.

There was a policy on challenging behaviour which outlined that alternative options were considered before a restrictive practice was to be used. A generic risk assessment on challenging behaviour was available in the house due to the high incidence of recorded episodes of challenging behaviour. Each incident of challenging behaviour was recorded and filed in the residential record for each resident. The report form included the nature of the episode of challenging behaviour, what was happening before the incident occurred and what immediate actions were undertaken. A formal review was undertaken for each episode with actions recommended if required. There was evidence in residents personal plans that detailed behavioural support plans were in operation for residents who presented with behaviours that challenged. There was also evidence of regular review of behavioural plans by the psychiatrist and psychologist. Training records confirmed that staff had received up to date training in the management of behaviours that challenged.

The inspectors saw that a restraint free environment was promoted as much as possible and that any residents that required restrictive procedures were referred to the committee on human rights which would review residents care if restraint is in use. One of the residents was using bed rails when in bed and a lap belt in the chair which the staff said he requested for his security. However there was no assessment seen for the use of the restraining devices and no evidence of other least restrictive alternatives having been tried as is required by the best practice guidelines and national policy.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

The inspectors saw that residents were assisted to access community based medical services such as their own GP and were supported to do so by staff that would accompany them to appointments and assisted in collecting the prescription as required. Out of hours services were provided by the local doctor on call service who attended the resident at home if required. There was evidence of multidisciplinary involvement in residents care. Psychiatry, social work, speech and language therapy and psychology services were available through the brothers of charity services and regular multidisciplinary team meetings were held where all residents care is discussed and reviewed.

There were planned supports in place where a resident had to attend an out-patient appointment in a hospital. Staff outlined that they would accompany the resident. The resident records indicated that staff kept a medical appointment record for each hospital visit by the resident or review by a healthcare professional. This included a summary of what was the reason for the healthcare appointment and the outcome of the review. The residential records also had written discharge letters following reviews in the Emergency Department and on call doctor services.

Residents were seen to have appropriate access to other allied health care services such as physiotherapy, occupational therapy, chiropody, optical and dental through the HSE and visits were organised as required by the staff. There was evidence in residents' personal plans of referrals to and assessments by allied health services and plans put in place to implement some treatments required.

The inspectors found that one resident had complex physical and nursing needs and had developed pressure sores and there was no evidence that the resident's well-being and welfare was maintained by a good standard of evidence-based care as there was no evidence of validated tools in use in the service. Personal plans viewed by the inspectors did not show ongoing assessments as is required by legislation. Therefore was no way of measuring and assessing residents increasing dependency needs and planning care in accordance with validated assessments as is required by legislation. The centre was not nurse led and there was no evidence of a wound care assessment chart for the resident with pressure sores and no scientific measurement of wounds to identify improvement or deterioration kept in the centre. The public health nurses were coming in to dress wounds twice a week and they held the records, the staff employed in the centre but on extra dressings in between if required but there were no records available to advise other staff if a full dressing was required over a weekend or holiday period.

The inspectors saw that in each house residents were fully involved in the menu planning. Meetings were held with the residents to plan out the meals for the week. The staff demonstrated an in-depth knowledge of the residents likes and dislikes. Inspectors noted that easy to read formats and picture information charts were used to assist some residents in making a choice in relation to their meal options. The food was seen to be nutritious with adequate portions. Residents to whom inspectors spoke stated that they enjoyed their meals and that the food was very good. Inspectors viewed the monitoring and documentation of some residents' nutritional intake and noted that referrals were made to the GP and speech and language. Some of the residents were seen to have

swallow plans with some residents requiring a soft diet. The inspectors observed that residents had access to fresh drinking water at all times.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

There were centre-specific medication management policies and procedures in place dated August 2014 which were viewed by the inspectors and found to be generally comprehensive. Inspectors were informed and saw that the psychiatrist generally prescribes residents medication and that medications are obtained from the residents' local pharmacist for each resident. The house had medication supplied in a version of monitored dosage system. The inspectors saw that references and resources were readily accessible for staff to confirm prescribed medication with identifiable drug information. This included a physical description of the medication and a colour photograph of the medication which is essential in the event of the need to withhold a medication or in the case of a medication being dropped and requiring replacement.

The centres policy was that non nursing staff were to have undergone two day training on safe medication administration and be assessed as competent by a nursing staff prior to any administration of medications to residents. Inspectors saw evidence of this medication training in staff files however many of this training had been undertaken in 2010 and had not received refresher training since then. There was no evidence of ongoing competency assessments or monitoring of medication practices by nursing staff. This was of particular relevance as many of the residents in the centre were on complex medication plans and were having regular changes to their medications that required monitoring.

The staff told the inspectors that the pharmacist gives advice to the staff in relation to the medications if required but there was no evidence of ongoing review and training on medications for residents. There was no evidence of audit by a pharmacist. Staff told the inspectors that they had changed to a new system of medication management using a prescription booklet in place of a prescription sheet which had been trialled on a number of residents but was now being implemented for all residents.

The inspectors viewed the prescription booklets and identified numerous unsafe

practices with medication documentation and prescribing that could lead to serious errors as outlined below.

- Medications were transcribed to the new booklet format by a social care leader where the policy states this can only be transcribed by a registered nurse.
- One medication transcribed had not been signed by the medical practitioner but had been administered by staff
- PRN medications had been omitted on the new medication chart for a resident who required same.
- There was no maximum dose prescribed for PRN medications
- Medications that required crushing was not prescribed as such for each medication that required crushing. It is a requirement of legislation that the medical practitioner prescribes crushed medications as medications which are crushed are used outside their licensed conditions and only a medical practitioner is authorised to prescribe medications in this format.
- Changes to Medication doses were not prescribed correctly the old dose was just crossed out and the new one written over it.
- Medications advised from a hospital appointment were just written on the medication booklet and not signed by a medical practitioner.

All of the above practices were identified as requiring immediate action at the feedback meeting.

Residents' medication were stored and secured in a locked cupboard and the medication keys were held by the staff on duty. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication. There were no residents that required scheduled controlled drugs at the time of the inspection.

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):

This was the centre's first inspection by the Authority.

Findings:

A written statement of purpose was available and it reflected the day-to-day operation of the centre and the services and facilities provided in the centre. The statement of purpose was found to be comprehensive and contained all the relevant information to meet the requirements of legislation under schedule 1 of the regulations.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

The Comeragh Services is one of a number of designated centres that come under the auspice of the Brothers of Charity Services South East. The Brothers of Charity South East provides a range of day, residential, and respite services in Waterford and South Tipperary. It is a not for profit organization and is run by a board of directors and delivers services as part of a service agreement with the HSE. There is a director of services who reports to the board of directors. The Brothers of Charity Comeragh services in Waterford is managed by a service manager who is the person in charge, he reports to the the regional services manager and is supported by a senior management team which comprises a social worker, a principal psychologist, a services manager responsible for health and safety, a consultant psychiatrist, a speech and language therapy manager and a Clinical Nurse Managers 2(CNM2) who has responsibility for residential services within the Comeragh service. The senior management team meet regularly.

The person in charge works full-time and has managed the service for numerous years. There was evidence from training records that the person in charge had a commitment to his own continued professional development. The person in charge is a qualified nurse in psychiatry and intellectual disability; He holds further qualifications in psychology for nurses ,teaching methods, a certificate in behaviour therapy for nurses and a certificate in nurse management. The inspectors formed the opinion that the person in charge had the required experience and clinical knowledge to ensure the effective care and welfare of residents in the centre. The (CNM2) takes responsibility in the absence of the person in charge for the residential service. Additionally the person in charge and CNM are available on call.

Inspectors noted that residents were familiar with the person in charge and approached him with issues and to chat during the inspection. Residents and staff identified the

person in charge as the one with overall authority and responsibility for the service. Staff who spoke to the inspectors were clear about whom to report to within the organisational line and of the management structures in the centre. However the inspectors found that there was a lack of clarity in the day to day operation of the centre in relation to who was involved in day to day management with specified roles and responsibilities for areas of service provision. This was evidenced for example by lack of accountability for medication management as discussed in outcome 12.

Staff who spoke with the inspectors said they had regular team meetings with the CNM and received good support from the CNM and person in charge, however they had not received any formal support or performance management in relation to their performance of their duties or personal development. The person in charge confirmed that although this was planned no staff had received an appraisal to date.

The regional services manager, the person in charge and CNM were actively engaged in the governance and operational management of the centre, and based on interactions with them during the inspection, they had an adequate knowledge of 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.

Inspectors saw that there was a copy of the National Standards and the Regulations were available to staff in the house along with other relevant documentation.

Inspectors noted that throughout the inspection the person in charge and staff voiced a commitment to improving standards of care for residents. There was a health and safety "Annual HIQA audit" and preparation tool. A six monthly assessment report was commenced with ongoing audits of the service were seen in relation to safety audits, fire drills, emergency plan to monitor the quality of care and experience of the residents. The person in charge had commenced unannounced visits to the centre in January 2014 and November 2014 to ensure effective systems are in place that support and promote the delivery of safe quality services however the inspectors noted audits and quality improvements needed to be further developed. There was not an annual review completed at the time of the inspection of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards. The management team said this was a work in progress and they were developing a template to use in relation to same.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

This was the centre's first inspection by the Authority.

Findings:

Inspectors reviewed a sample of staff files and noted that all of the requirements of Schedule 2 of 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 were available. The person in charge stated that a large proportion of the staff which included him had been employed in the service for a significant period of time and there was a high level of continuity of staffing. This was confirmed by staff that inspectors met who had worked in the centre for long periods. There was evidence that new staff received a comprehensive induction programme.

During the inspection inspectors observed staff interacting and speaking to residents in a friendly, respectful and sensitive way. Based on observations of inspectors staff members were very knowledgeable of residents individual needs and this was very evident in talking to staff and residents. Residents spoke very positively about staff saying they were caring and looked after them very well. Staff that worked alone stated they generally felt well supported but felt the increasing dependency needs of the residents made it difficult to provide care without assistance.

Inspectors were not satisfied that the staff available during the inspection was appropriate to meet resident's needs as there was only one staff member at night and for long periods during the day. As discussed earlier one resident had increased dependency needs and required the assistance of two staff to assist with providing personal care to the resident. Staff reported that if the resident required care that took two staff during the day a staff member had to make a journey from the day service and the resident was required to wait for their arrival. At night it was even more difficult to get assistance. Inspectors required that staffing levels were to be reviewed to ensure that safe and appropriate care was provided to all residents.

As discussed in previous outcomes based on a review of training records by inspectors, not all staff had received up-to-date mandatory training in fire and adult protection. Training records confirmed that a number of staff had received training in infection control, person-centred plans, personal development relationships and sexuality,

management of behaviour that challenges, first aid and medication management. All of the care staff had undertaken as a minimum a Further Education Training Awards Council (FETAC) level 5 qualifications in healthcare.

There was evidence that team meetings took place regularly and the minutes were kept of issues that were discussed. The inspectors viewed a sample of the minutes which showed that the topics discussed included all issues relevant to the centre' and residents. Staff who spoke to inspectors confirmed that such meetings were held on regular basis.

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):

This was the centre's first inspection by the Authority.

Findings:

This outcome was not inspected against fully and only healthcare records are referenced here

The management of healthcare records required improvement. There were three sets of resident records: the services record, the medical record and the residential record. The services record was maintained in the main service office and contained:

- person centred planning goals for the year
- multi-disciplinary reviews with input from psychologists, team leaders and psychiatrists
- risk management assessments
- day support and service records
- multidisciplinary reports e.g. psychology and social work reports
- challenging behaviour incidents
- incident report forms

The medical record was maintained in the main service office and contained:

- resident personal profile
- consultant psychiatrist reviews

- general practitioner and hospital visits
- health supports e.g occupational therapy and physiotherapy reports
- health appointment record sheets
- investigation records including blood test results and x-ray reports

The residential record was held in the house where the residents lived. This contained:

- a photograph of the resident
- copy of the contract of service
- resident profile including name, contact list, GP details
- personal emergency evacuation plan
- person centre outcome measures
- multidisciplinary planning meetings
- support plans
- day to day communication about the resident
- GP, hospital and consultant specialist visits
- Finances.

Inspectors found that there was duplication of material in each of the three records which can lead to errors. It was also found that a lot of information was historical information dating back to sometimes over 20 years ago.

Judgment:

Non Compliant - Minor

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:

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services South East
Centre ID:	OSV-0003277
Date of Inspection:	14 January 2015
Date of response:	12 February 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The human rights committee did not specify who the 12 members were

Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the

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

freedom to exercise choice and control in his or her daily life.

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

A list of the current membership of The Human Rights Committee has been forwarded to each Designated Centre. Staff have been instructed to ensure that residents are informed of the membership names at their House Meetings.

Proposed Timescale: 12/02/2015

Theme: Individualised Supports and Care

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

The complaints procedure was not prominently displayed in the centre

Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

Information on how to make comments, compliments and complaints has been produced in leaflet form. This leaflet is now displayed on the notice/information board in the designated centre. Staff have been instructed to ensure that residents are made aware of this at their next House Meetings.
A copy of the leaflet has been sent to families of the residents in the Designated Centre.

Proposed Timescale: 12/02/2015

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 identify a nominated person with oversight of the complaints process to ensure that all complaints were appropriately responded to.

Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

This has been addressed in the Information Leaflet i.e. The Complaints Officer with oversight of the Complaints Process, has been named in this leaflet.

Proposed Timescale: 12/02/2015

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 identify the designated complaints officer.

Action Required:

Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

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

A named Social Worker is nominated to deal with complaints by or on behalf of residents of the designated centre. The name and a photograph of this person are now displayed on the notice board in the designated centre and staff have been instructed to inform residents of this information.

Proposed Timescale: 12/02/2015

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 admission policies and practices did not take account of the need to protect residents from abuse by their peers.

Action Required:

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

A review of the Enrolment Policy, which covers admissions, is currently underway. We will ensure that this complies with the above regulation.

Proposed Timescale: 31/03/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Residents are restricted in their movement and accessing areas in the house due to the poor design of the building.

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:

A review of the needs of one resident who is restricted in accessing areas of the designated centre has been carried out to assess the suitability of his placement in this designated centre and his possible re-location to a more accessible house.

A more suitable mobility aid for the second resident is being sourced. This will make all areas of the house accessible to him.

Proposed Timescale: 30/04/2015

Theme: Effective Services

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

The inspectors noted paint off the walls and door frames in areas of the centre.

Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

This will be addressed through our regular maintenance schedule.

Proposed Timescale: 30/04/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The risk management policy it did not contain the measures and actions in place to control the specified hazard of unexplained absence of a resident.

Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

This has been addressed by an amendment to the Policy.

Proposed Timescale: 12/02/2015

Theme: Effective Services

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

The risk management policy it did not contain the measures and actions in place to control the specified hazard of accidental injury.

Action Required:

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

This has been addressed by an amendment to the Policy.

Proposed Timescale: 12/02/2015

Theme: Effective Services

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

The risk management policy it did not contain the measures and actions in place to control the specified hazard of aggression and violence.

Action Required:

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

This has been addressed by an amendment to the Policy.

Proposed Timescale: 12/02/2015

Theme: Effective Services

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

The risk management policy did not contain the measures and actions in place to control the specified hazard of self harm.

Action Required:

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

This has been addressed by an amendment to the Policy.

Proposed Timescale: 12/02/2015

Theme: Effective Services

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

Staff outlined water soluble bags were not available for any items that were soiled.

There wasn't any separate waste disposal for clinical waste.

A food bin was observed on the counter top in the kitchen which was directly beneath the hand towels for drying hands.

Action Required:

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

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

- 1) Water soluble bags for soiled items are being sourced and will be made available.
- 2) A separate waste disposal bin for clinical waste is now in use.
- 3) Staff have been reminded that the food bin should not be located on the counter top.

Proposed Timescale: 1): 27/02/2015. 2): Completed. 3): Completed

Theme: Effective Services

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

Not all staff had up to date 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:

These staff are booked onto the next fire training which will take place on 18/05/2015.

Proposed Timescale: 18/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was no assessment seen for the use of the restraining devices and no evidence of other least restrictive alternatives having been tried as is required by the best practice guidelines and national policy.

Action Required:

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

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

An assessment regarding the use of bed rails and lap belt for the individual will be carried out in line with best practice.

Proposed Timescale: 31/03/2015

Theme: Safe Services

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

Training records confirmed that not all staff had not up to date training in protection and abuse prevention.

Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

The relevant policy is currently being revised and staff refresher training in protection and abuse will be rolled out when this is completed.

Proposed Timescale: 30/06/2015

Theme: Safe Services

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

The system in place to manage residents money was not sufficiently robust.

Action Required:

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

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

A review by the PIC in consultation with the finance department will be carried out to ensure that the system currently in place to manage residents' money is sufficiently robust.

Proposed Timescale: 31/03/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There was no evidence that the resident's well-being and welfare was maintained by a good standard of evidence-based care as there was no evidence in residents personal plans of validated tools and ongoing assessments in use in the service to plan and direct care required.

Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

- 1) A nursing needs assessment has been carried out, using a validated assessment tool, for the one resident identified in the inspection report who required same.
- 2) Each resident has an annual medical check/assessment.
- 3) The Provider is currently considering which validated assessment tools are most appropriate in a social care context.

Proposed Timescale: 1: Completed. 2): Completed. 3): 31/03/2015

Outcome 12. Medication Management

Theme: Health and Development

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

The inspectors viewed the prescription booklets and identified numerous unsafe practices with medication documentation and prescribing that could lead to serious errors as outlined below.

- Medications were transcribed to the new booklet format by a social care leader where the policy states this can only be transcribed by a registered nurse.
- One medication transcribed had not been signed by the medical practitioner but had been administered by staff
- PRN medications had been omitted on the new medication chart for a resident who required same.
- There was no maximum dose prescribed for PRN medications
- Medications that required crushing was not prescribed for each medication that required crushing. It is a requirement of legislation that the medical practitioner prescribes crushed medications as medications which are crushed are used outside their licensed conditions and only a medical practitioner is authorised to prescribe medications in this format.
- Changes to Medication doses were not prescribed correctly the old dose was just crossed out and the new one written over it.
- Medications advised from a hospital appointment were just written on the medication

booklet and not signed by a medical practitioner.

Staff did not have up to date medication management training.

Action Required:

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

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

The provider has in place a policy on the Administration of Medication which details the practices required for all the above areas. The practices observed by the inspector were not in line with the policy. The errors noted by the Inspector were corrected immediately. Staff have been instructed by the PIC and the Residential Team Leader that they must follow the policy and procedures and the Team Leader will review the practices.

Medication Management refresher training for staff is scheduled for April 2015. Staff in the designated centre will be prioritised for this training.

Proposed Timescale: 30/04/2015

Theme: Health and Development

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

There was no evidence of ongoing review, advice and training on medications for residents by the pharmacist.

There was no evidence of audit by the pharmacist.

Action Required:

Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

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

We will be in contact with the relevant pharmacists to discuss how we can facilitate them in meeting their obligations under relevant legislation and guidance.

Proposed Timescale: 30/06/2015

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 inspectors found that there was a lack of clarity in the day to day operation of the

centre in relation to who was involved in day to day management with specified roles and responsibilities for areas of service provision.

Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

The PIC will discuss the specifics of the above with the staff team and ensure that any clarifications that are required by staff are provided.
This will be reinforced at Staff Support Meetings.

Proposed Timescale: 27/02/2015

Theme: Leadership, Governance and Management

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

Staff had not received any formal support or performance management in relation to their performance of their duties or personal development.

Action Required:

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

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

Staff support meetings have commenced.

Proposed Timescale: Ongoing

Theme: Leadership, Governance and Management

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

There was no annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Action Required:

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

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

The Annual Review is in progress.

Proposed Timescale: 27/02/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

Inspectors were not satisfied that the staff levels available in the centre were appropriate to meet resident's needs

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:

The provider is currently assessing the changed needs of one resident in order to establish the appropriate staffing level and skill mix.

Proposed Timescale: 30/04/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

The management of healthcare records required improvement.

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:

While all information required under Schedule 3 is available, the PIC is reviewing the number of files maintained in relation to an individual with a view to rationalising them to avoid duplication.

Proposed Timescale: 31/03/2015