

**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 Health Service Executive
Centre ID:	OSV-0002454
Centre county:	Monaghan
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Kevin Carragher
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Siobhan Kennedy, Paul Pearson
Type of inspection	Announced
Number of residents on the date of inspection:	8
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 29 June 2015 10:30 To: 29 June 2015 19:30

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 was an announced inspection completed in response to an application by the provider for registration of the designated centre as required by the Health Act 2007. The designated centre consisted of one community house located in Co. Monaghan and operated by the Health Service Executive. This was the second inspection of the centre by the Authority. The inspectors found that the provider had demonstrated a responsive approach to regulation. While some actions taken by the provider to address and address areas of non-compliance identified, further improvements are required in some areas of the service as discussed in the body of this report and associated action plans to bring the designated centre into compliance with the regulations.

This inspection was facilitated by the person in charge who was present at the opening and closing meeting. As part of the inspection process, inspectors met with residents and staff, reviewed documentation and observed practice. Completed pre-inspection questionnaires issued by the Authority were also reviewed. Feedback was generally complimentary of staff within the centre and the quality of service provided to residents. Inspectors found that staff engaged with residents in a dignified and respectful manner and residents spoken with confirmed their satisfaction and happiness with living in the designated centre.

The inspectors found that service improvements had been implemented that positively impacted on the quality of life of residents since the last inspection in June 2014. Findings that the person in charge was not in a full-time position in the designated centre compromised areas of resident care including leadership with transitioning of a resident into the centre. This resident had high support needs as found on inspection and which were addressed by the provider with increased care staff support. The provider advised the Authority following inspection that the person in charge would commence in a full-time, on-site position in the centre by 30 October 2015.

Non-compliances were identified with twenty two regulations on this inspection, thirteen of which are the responsibility of the provider and nine are the responsibility of the person in charge. Compliance was found in seven outcomes. Substantial compliance requiring minor improvement was found in Outcome 5: Social Care Needs and Outcome 10: General welfare and Development

Moderate non - compliance was identified in the following Nine Outcomes:

Outcome 1: Residents' Rights and Consultation,
Outcome 7: Health and Safety and Risk Management
Outcome 8: Safeguarding and Safety
Outcome 11: Healthcare Needs
Outcome 12: Medication Management
Outcome 14: Governance and Management.
Outcome 16: Use of Resources
Outcome 18: Records and documentation
Outcome 17: Workforce.

The action plan at the end of this report identifies the required actions the provider/person in charge is required to take to ensure the designated centre is in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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):

No actions were required from the previous inspection.

Findings:

The inspectors found there were systems in place for the management of complaints. The complaints procedure was displayed in accessible format. The complaints log was reviewed and referenced eight complaints and while there were no complaints under investigation at the time of inspection, the documentation logged was inconsistent. The inconsistencies were identified in relation to the details of the complaint investigation maintained by the person in charge who had responsibility for completion of an initial screening of the complaint. Not all records provided to the inspector evidenced that complaints had been promptly investigated, what actions had been taken and if complainants were satisfied with the outcome and were informed of the appeal process as per the Regulations. Inspectors observed that some of the complaints logged were in reference to concerns by relatives regarding safeguarding of their relative (resident) when incidents of challenging behaviour were exhibited by some residents. Some complaints were also from residents who expressed dissatisfaction in relation to the physical and/or psychological impact of this behaviour was having on them. This finding is discussed further in outcome 6.

The inspectors found that the right of residents to engage in individual meaningful activities of their choice was evidenced. Each resident was facilitated and assisted to pursue individual interests including independently travelling on public transport to visit family in other parts of Ireland. Individual preferences such as wearing jewellery and carrying a handbag was encouraged and respected. Another resident enjoyed completing maths and staff facilitated this activity by generating calculations and correcting them on completion. A day activation programme was rescheduled to give a resident time to rest and/or pursue personal interests in the afternoons. Residents also from time to time attended various activities or outings in the local town or visited local

amenities.

Residents had access to two transport vehicles provided for use by the community house.

Residents could make choices about their daily lives such as when to go to bed and when to get up. Staff were observed interacting with residents in a respectful manner, consulting with them and seeking their views with regard to the delivery of their care. Residents were encouraged and assisted to personalise their bedrooms to reflect their individuality and interests.

A weekly residents' meeting was convened where residents made suggestions and made decisions about planning and running of the community house. There was evidence from the minutes of interaction and involvement by residents in this forum. Their views were encouraged and were acted on by staff. Residents told the inspectors that they liked their home and the activities they participated in on a day to day basis such as going to the supermarket for the groceries, going to a local hotel and visiting their families.

There was a policy advising staff on managing residents' property and finances, as required by the Regulations. Each resident had an assessment completed to assess level of support required by staff with managing their personal finances. The provider and person in charge had put satisfactory arrangements in place to protect the property and the finances of residents with signatures of two staff for all transactions and a log of all monies maintained. Personal property lists were maintained however a sample reviewed by inspectors were not dated. This finding is addressed in outcome 18.

All residents had private accommodation in the form of their own bedroom. On this inspection, inspectors found that some residents entered other residents' bedrooms without permission. The inspectors were told that some residents expressed dissatisfaction with others entering their bedrooms at will. Residents were not provided with the means to safely lock their bedroom doors for their privacy if they wished. Showers/toilets were fitted with locks in the designated centre.

While an advocacy service was available to residents to support their choice and decision making, arrangements were not in place to ensure advocates who would support residents were known to them.

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 were informed that work was in progress on developing accessible format personal planning templates and resident guides for each community house. Inspectors observed that some documents were provided to residents in accessible format such as the complaints procedure. Staff photographs were displayed to reflect the duty rota and the menu of the day was also available to residents in a pictorial format to facilitate their informed choice.

There was also evidence that residents with speech deficits were appropriately referred for assessment for use of assistive technology to support their needs.

The Inspector found that staff were aware of the communication needs of residents and a detailed communication assessment was documented. Some residents had speech deficits. Staff demonstrated a comprehensive understanding of the meaning of some residents' communication methodologies. Personalised documentation was developed referencing each resident's communication gestures and sounds to assist their communication with those less familiar with them. Lámh language methods were used with some residents to assist their vocabulary and language skills. Staff were trained in the Lámh language and supported a resident who used this communication methodology.

Inspectors reviewed the policy informing management of residents' communication and found that it did not adequately inform the needs of residents in the centre. This finding is addressed further in outcome 18.

Residents had access to television, radios and telephones.

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:

There was a policy in place which advised on appropriate procedures to support visiting of residents in the designated centre. Residents were supported and empowered where

appropriate, with staff assistance to maintain family contacts which included visiting their families and for some residents, staying overnight. Residents were also observed by inspectors to be encouraged by staff to maintain family contact by telephone. While there was evidence of some residents maintaining links with the community, this could be improved for others.

There were no restrictions to visitors in the centre unless requested by the resident or supported by their risk assessment. Inspectors found clear evidence from review of the personal records of residents, feedback from the Authority's pre-inspection questionnaires and from speaking to residents and staff that where available, family members were actively encouraged and involved in the lives of residents. From a sample of records reviewed, there was also evidence that family members were involved in residents' personal plan meetings and were consulted regarding any change in the residents' health or well-being.

While each resident had single bedroom accommodation, there were adequate areas in the centre for residents to meet their visitors in private if they wished. Each house had a visitors' book which was up to date with a record of visitors who attended the centre on the days of inspection.

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:

The organisation had an admissions policy in place which included the procedures to be followed for transfers, discharge and temporary absence of a resident. This policy document was reviewed on inspection and while no deficits were found in respect of resident care on the days of this inspection, the policy did not adequately inform all aspects of these procedures. The policy did not adequately inform the procedures to take should an emergency occur or temporary absence in respect of a holiday, visiting family or an admission to hospital. The policy did not inform the procedure to be taken if a resident was admitted to hospital including the information to be communicated to the acute setting and the support, if any, the resident would receive from the designated centre whilst temporarily absent from same. The admission procedure did not adequately inform residents' choice or transition needs when moving into the centre from care in the family home or another service. This finding is addressed in outcome

18. There was one resident in transition into the service from the community on the day of inspection in the designated centre. A policy document was available.

Inspectors found that each resident had a contract detailing terms of residency, aspects of care covered as distinct from services not covered by the fee to the resident. Some contracts were countersigned in agreement by residents.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

All residents living in the centre had personal plans in place which identified their health, personal and social care needs. The Inspectors reviewed a sample of residents' personal support plans and found that they were completed in consultation with them and/or their significant others. Monthly evaluations ensured progress was regularly monitored and reviewed in response to changing needs. While there was evidence that each resident's full participation was encouraged in the annual review of their personal plans, these reviews were not multidisciplinary as all healthcare professionals involved in residents' care were not involved in annual reviews.

Each resident had a care plan developed to meet their assessed healthcare needs. Risk assessments were completed to inform social care needs such as visiting family/friends and accessing the community. Personal plan documentation referenced assessments of residents' emotional well-being, numeracy and literacy skills, concept of time, spiritual needs, nutritional needs, independence, personal grooming and sharing their environment. Additional assessments of need were completed for some residents with other vulnerabilities informed by use of accredited assessment tools to inform their manual handling and nutrition needs implemented since the last inspection.

There was evidence of progress by most residents with achieving their goals and in making decisions about new achievements to work towards. However, goals developed for some residents did not maximise their full potential with achieving their wishes. For example, one resident identified a goal to photograph house events and develop a

scrapbook with the photographs. However, the plan indicated that staff would purchase a disposable camera and scrapbook for the resident as opposed to this activity being completed by the resident concerned as part of achieving their overall goal.

Each resident attends a day activation programme with the exception of one resident who has a structured activation plan in place to engage in activities of interest supported by staff in the centre. Apart from day programmes residents were supported by staff to enjoy day trips, attending local social events, cinema, eating out, home visits and swimming among other events. Inspectors observed that family contact and spending time with family in their homes was of great importance to most residents. Many residents went home to the care of their family at weekends or visited for periods during the day as appropriate and in accordance with their risk assessments.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

The designated centre is a purpose built bungalow, located on the outer perimeter of the town of Monaghan and is wheelchair accessible. Inspectors found that the design and layout of residents' bedrooms met their needs. While the overall accommodation met the needs of most residents, it did not meet the needs of one resident. This finding had been identified by the management team and plans were in progress to convert an existing large premises to the back of the centre into supported living accommodation to meet the assessed needs of one resident as confirmed by the Provider. Residents' accommodation consists of a sitting room, a relaxation room, a large kitchen dining room and utility room. The house has two large communal showers/toilets and eight single bedrooms, two of which have are en-suite. Grab rails were fitted in toilets and showers. The utility room contained a washing machine and dryer.

Residents' bedrooms were person centred and residents told the inspectors they had control over the décor in them. The inspectors observed that bedrooms were personalised by residents to reflect their personality and interests. The centre was clean and well maintained with the exception of one shower door which needed repair. The centre was designed in a way that access was available to a patio and lawned area to

the back of the centre from the kitchen/dining area and a point in another part of the building. Seating was provided on the patio for residents' comfort, which was brightly painted by the residents. The back of the centre was enclosed by wooden fence to provide residents with a safe and secure area for their use. A bedroom window overlooking the patio was fitted with glass that obscured view inwards to protect a resident's privacy.

Service records for equipment in the house were available and up to date. There was adequate parking to the front of the centre.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

A Regional safety statement was available and was updated for 2015. The health and safety of residents, staff and visitors was found to be generally promoted in the designated centre on the days of inspection. A review of documentation evidenced that the centre had the requisite risk management policy and documentation and that this documentation was centre-specific. There was a risk register that reflected risks present in the centre, demonstrated that risk assessments were being conducted on an ongoing basis and that control measures were being implemented to address these risks. All potential risks were identified and assessed with concomitant controls stated to mitigate level of risks found.

Inspectors found that the necessary fire safety procedures were in place to safeguard residents and others against the risk of fire. There was evidence of regular checks and good housekeeping practice with respect to fire safety.

Inspectors reviewed the documentation relating to the maintenance and servicing of fire equipment and were satisfied that the appropriate maintenance and checks were occurring at regular intervals. Residents also had personal evacuation plans in place and there was evidence that regular fire drills took place. However, times of fire drills were not consistently recorded to demonstrate that fire drills were conducted to reflect the conditions that would be present both at day and night including the number of staff on duty and the location of residents at various times. There was evidence that a resident in the community house refused to leave. There was a reference procedure informing how this resident's evacuation would be managed in the event of a fire occurring at

night but did not specifically inform night-time procedures when one staff member was on duty. Arrangements for reciprocal support with another neighbouring community house in the event of an evacuation being required during the night was not evidenced in the fire drill information. These arrangements were not explicit or adequately risk assessed to ensure residents in the designated centre were adequately supervised in the event of the one staff member on duty in the designated centre providing support to a neighbouring designated centre in the event of an evacuation being required.

The community house was fitted with a fire alarm system and emergency lighting throughout. The layout of the house ensured there were adequate escape routes from the building in the event of fire. A number of fire exit doors were locked with a key, particularly at night. Inspectors found that while a loose key was provided in the vicinity of the door, there was potential for misplacement in the absence of break glass units to ensure access to a key at all times. Assessment and documentation had been completed identifying residents with ability to independently operate fire exit door key-locks. A fire door located in a corridor was not operational with a push to open method due to a fitted latch mechanism. This finding could potentially compromise evacuation. All internal doors were fitted with self-closure units.

The inspector observed that the centre was visibly clean and well maintained. Adequate hand hygiene facilities were provided and staff engaged in hand hygiene as appropriate. Waste bins provided for hazardous healthcare, non-healthcare and domestic waste were in compliance with the services corporate policy advising on waste management and infection control and prevention procedures.

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):

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

Findings:

The designated centre has a policy in place titled 'Guidelines on the Protection from Abuse of Vulnerable Adults with a Disability' advising on prevention, detection and response to abuse. As discussed in outcome 2, advocacy services for residents required

improvement. Inspectors confirmed that all staff had received training in safeguarding vulnerable adults. Staff spoken with voiced the view that the welfare of the residents was paramount and they had a responsibility to report any suspicion or allegation of abuse. All members of a regional safe-guarding team had not been established to support the HSE National Safeguarding policy requirements and as such implementation of the policy into practice was hindered in the absence of clear referral and support pathways.

The organisation had a policy in place to inform support procedures for residents who exhibited behaviours that challenged and the use of restrictive practices. Staff in the house had attended PMAV (Professional Management of Aggression and Violence) training and training on positive behavioural support which included de-escalation procedures.

Inspectors reviewed reports in relation to peer on peer incidents. These incidents were reviewed and addressed with remedial actions informing residents' positive behavioural support plans. However, inspectors found that reported incidents were continued by a small number of residents. While there was 1:1 support in place for part of each day and an additional transport vehicle provided to ensure one resident was supported to engage in 1:1 therapeutic activation, inspectors were not assured that incidents of challenging behaviour exhibited did not negatively impact on the psychological well-being of the other residents. The inspectors requested a further review of the arrangement in place to ensure residents physical and psychological well-being was assured at all times. Further information provided by the provider since the inspection referenced increased 1:1 support by increased staffing numbers. In addition, plans were progressed to support this resident in supported living accommodation by refurbishment of an existing premises into living accommodation. The provider also provided assurances that the person in charge would be relieved from responsibility for a day service unit and would be assigned on a full-time basis from 30 October 2015 in line with the regulations and to ensure full-time on-site leadership for staff with managing residents' with challenging behaviour. A clinical psychologist was involved in reviews of challenging behaviour and supported residents with episodes of same as confirmed by residents' documentation. Residents were reviewed as required by Disability psychiatric services.

Chemical restraints were taking place at the time of this inspection as part of a positive behavioural support strategy for some residents. A 'use of the kitchen/dining room' schedule was also in place as a safeguarding measure for residents and as part of a positive behavioural support plan for one resident. While this finding placed environmental restrictions on all residents, there was evidence that the arrangement was being monitored to ensure that it did not negatively impacted on any of the residents. The arrangement was time-limited and will cease with completion of the supported living unit. While protocols were in place for use of PRN (as required) chemical restraints, administration of same was not clearly reflective of the National Policy 'Towards a Restraint Free Environment' and required review to demonstrate use as a last resort following adequate trialling of alternative means to de-escalate negative behaviours. This finding is also referenced in outcome 18.

Staff-resident interactions were observed on the days of inspection and inspectors observed staff to be supportive and caring towards residents.

<p>Judgment: Non Compliant - Moderate</p>

<p>Outcome 09: Notification of Incidents <i>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</i></p>
<p>Theme: Safe Services</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Inspectors reviewed the accident/incident log and confirmed that all incidents as required by Regulation 31 had been notified to the Chief Inspector. All restrictive practices were notified appropriately. The person in charge demonstrated the appropriate knowledge of their statutory obligation to notify the Chief Inspector.</p>
<p>Judgment: Compliant</p>

<p>Outcome 10. General Welfare and Development <i>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.</i></p>
<p>Theme: Health and Development</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: There was no policy available to staff to advise on procedures to ensure residents' access to education, training and development in the designated centre. This finding is discussed in outcome 18. All residents had access to a structured programme outside the centre to pursue their personal and occupational development. However one resident choose not to attend day services and was facilitated to engage in a structured schedule of activities including personal development and learning a new skill in response to personal choice and assessed needs.</p>

Some residents engaged in light housework and baking. Outside of day programme schedules residents were encourage to voice their opinion at weekly house meetings regarding pursuing interests and leisure activities they enjoyed which were facilitated. As discussed in outcome 6, some residents' ambitions stated as goals required review to ensure they were meaningful and developmental. There was one resident in transition. This resident's documentation evidenced that the service was supporting this resident to transition with assistance by allied health professionals and a behavioural support plan. In addition, the service determined that this resident's needs could be better met in supported living accommodation and were progressing this arrangement to ensure improved outcomes for this resident.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Inspectors reviewed a sample of residents' personal plans and were assured that residents' needs were reviewed on an annual basis. Health care needs were identified in this annual assessment. Inspectors found on the last inspection in June 2014 that

- appropriate plans of care were not developed as appropriate,
- there was no referral to relevant allied health professionals to meet dietary intake or modification of food consistency needs.
- there was an absence of evidence to support that specialist diet meal preparation decisions were informed by a dietician,
- residents with swallowing issues and in receipt of modified consistency foods were not reviewed by a speech and language therapist as appropriate.

Inspectors found on this inspection that although care plans were in place to reference residents' individual healthcare need, the interventions prescribed to meet some of those needs did not adequately inform practice. There was also evidence that healthcare referrals for assessment by allied health professionals required improvement. For example, a resident assessed as being unsteady on their feet was not reviewed by an occupational therapist as appropriate. Another resident with significant health issues related to low serum sodium levels requiring replacement therapy did not have assessment by a dietician to ensure their dietary needs were met. In addition, this resident's care plan documentation advised that this resident was not on a fluid

restriction due to another healthcare condition. The documentation advised that they should not over-indulge. However no reference was made to the amount of acceptable fluid intake. This resident had commenced on a medication to control symptoms of a healthcare condition, which may adversely affect their sodium serum levels. Although reviewed by some medical consultants, some residents were not appropriately referred for review by medical consultants specialising in the care of their medical condition. The Inspectors reviewed the records for residents and found that they had access to a general practitioner of their choice, including an out of hour's service. There was evidence that residents with swallowing difficulties and in receipt of modified consistency foods were referred for speech and language therapy assessment as appropriate.

Residents spoken with stated that they liked the food provided. There was evidence that residents' body weights were monitored with increased frequency for those at risk of weight loss/gain. Menus were in accessible format and inspectors observed that residents were provided with opportunity to have snacks and drinks throughout the day outside of their main meals.

The nutrition policy available to advise staff was not adequate as it did not advise on specialised dietary management for residents in the centre with complex nutritional needs and did not adequately advise on all aspects of nutritional assessment. This finding is addressed in outcome 18. Staff had training in hand hygiene and nutrition and healthy eating.

Some residents had a diagnosis of epilepsy. All staff had attended training on Epilepsy Awareness to inform their practice.

Records of referrals, clinical interventions and treatments were maintained in each resident's documentation.

Residents confirmed that they had the opportunity to attend annual review meetings which included their healthcare. There was evidence that staff also met with residents after an annual review meeting to ensure their understanding regarding the outcome.

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):

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

Findings:

An approved operational policy to inform practice was available on the day of inspection. On the last inspection of the centre in June 2014, the designated centre did not have a current policy in place regarding medication management. A draft policy which was under review as a result of findings of inspectors at an organisational level was found to be satisfactorily implemented on this inspection. However, review of this policy on inspection evidenced improvement required in the information to inform appropriate secure storage and disposal of unused or out of date medications. This finding is addressed in outcome 18. The medication policy was centre-specific to inform practice in respect of staffing arrangements however, it did not adequately inform return of unused or out of date medications. While, weekly checks were completed on medication stock in the centre, the inspectors found that a medication still in stock was expired since December 2014.

All residents' medication was administered by registered nurses in the centre. All staff had completed training in medication management. Some medication management practices were found not to be in line with professional practice guidelines and the legislation. The inspectors witnessed an incident of pre-signing for medication administration for a resident.

Staff in the centre completed a medication audit each quarter. However, these audits did not identify deficits as found on inspection. The pharmacist did not complete medication audits as part of their obligations and as required by the regulations. The inspectors found that a resident was prescribed for a medication they did not require as confirmed by staff. Each residents' GP reviewed and prescribed their medications.

Judgment:

Non Compliant - Moderate

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:

As part of the application to register the designated centre under the Health Act 2007, the provider was required to submit a Statement of Purpose to the Chief Inspector. Inspectors reviewed the Statement of Purpose dated 11 May 2015 and found that it accurately described the service provided and contained the information as required by

Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013,

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):

No actions were required from the previous inspection.

Findings:

There was a clear management structure in place. The provider nominee was the regional manager for the service. The provider nominee is supported by a regional director of nursing and assistant director of nursing. The person in charge reports directly to the director of nursing. She meets with the Director of Nursing formally on a monthly basis at a forum for all persons in charge in the designated centres in the region. The person in charge also meets with the director of nursing approximately every 8 weeks. Both these meeting forums were informed by an agenda and minuted. There was also evidence that the staff employed to work directly in the designated centre met regularly as a group with the person in charge. The director of nursing had commenced appraisal with the person in charge as part of her regional role.

The person in charge was available throughout the two days to facilitate the inspection. The person in charge has the necessary qualifications and experience to ensure compliance with the legislation and demonstrated adequate knowledge of the operation of the designated centre. The evidence supported her involvement in the governance, operational management and administration of the centre. The person in charge is employed as a Clinical Nurse Manager Grade 2 and had responsibility for the designated centre and a day service. The absence of a full-time person in charge did not ensure consistent on-site leadership during the transitioning of a resident who required high levels of support. There was also evidence of medication management non-compliance the regulations and with professional guidelines as discussed in outcome 12. Care plans to adequately inform meeting residents' assessed needs required improvement as discussed in outcome 11. Inspectors also found that restraint management did not consistently reflect the National Policy guidelines as discussed in outcome 8. Since the inspection, the provider has advised the Authority that this arrangement will

cease on the 30 October 2015 with the person in charge being assigned full-time responsibility of the designated centre.

Although at an early stage, there was evidence of a system in place to monitor the quality and safety of care and quality of life of residents. There was evidence of audits of medication management practices, infection prevention and control and health and safety. Some actions were taken to address deficits identified but it was not clear if all deficits were addressed as action plans were not developed clearly identifying the actions to be taken and to enable tracking to satisfactory completion.

There was evidence that the provider or the director of nursing nominated on behalf of the provider had visited the designated centre regularly in the previous six months and the provider produced a report on the quality and safety of care and support provided in the centre as required by Regulation 23.

Judgment:

Non Compliant - Moderate

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 deputising arrangements in place should the person in charge be absent and the Provider was aware of his responsibility to notify the Chief Inspector of the absence. To date the person in charge had not been absent for a period of more than 28 days.

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:

The Inspectors found that the centre was not adequately resourced with a full-time person in charge on the days of inspection. However, since the inspection, the provider has advised the Authority that this arrangement will cease on the 30 October 2015 with the person in charge being assigned full-time responsibility of the designated centre.

The inspectors found that high staffing resources required to support a resident transitioning into the service were increased..

Inspectors found that improvements were required to ensure timely access to allied health professionals and specialist medical services for some residents with complex needs. This finding is discussed in outcome 11.

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):

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

Findings:

The inspector reviewed a copy of the staffing rota for the community house. There was a registered nurse on-duty throughout the 24 hours. The person in charge also had responsibility for a local day activation service attended by residents and attended the centre on a part-time basis. This finding is discussed further in outcome 14. The person in charge attended the centre each day and was recorded on the duty roster. She was supported in her role within the designated centre by registered intellectual disability, registered psychiatric nurses and care staff.

Inspectors reviewed a sample of staffing rosters and confirmed that the staffing levels on the day of inspection were reflective of the rosters. Staff spoken to on the day of

inspection stated that they felt that the number of staff on duty was sufficient to meet the needs of the residents.

The staffing levels for the designated centre were:

Staff Nurse: 8.00 - 20.00 x 7 days per week

Care Assistant: 8.00 - 20.00 x 5 weekdays per week

Care Assistant: 08:00 - 21:30hrs x 5 weekdays per week

Care Assistant: 14:00 - 20:00hrs x 5 weekdays per week

Care Assistant: 16:00 - 20:00hrs x 5 weekdays per week

Care Assistant X 2: 08:00hrs - 20:00hrs on Saturday and Sunday each weekend

Care Assistant X 2: 09:00hrs - 21:00hrs on Saturday reducing to 1 Care Assistant on Sundays each weekend

Staff Nurse: 20.00hrs - 08.00hrs x 7 nights per week (lone worker). There was a lone worker policy in place.

The day-time staffing level arrangement ensured residents could attend social activities in the evening and at weekends. However a review of staffing levels and skill mix at night was required to ensure the needs of residents could be met with regards to safe evacuation of residents in the event of a fire with one staff member on duty as discussed in outcome 7.

The person in charge told inspectors the staffing levels and skill mix were subject to on-going review and monitoring to ensure the needs of residents were met.

Inspectors reviewed a sample of training records for staff. Of the records reviewed staff had completed mandatory training requirements in addition to training in areas reflecting the needs of residents to support and inform their practice. There was evidence that education and training on medication management was provided since the last inspection in June 2014 as required in an action plan to address non-compliance. However, education on menu planning for residents with specific dietary needs required further development.

Inspectors were verbally informed that a new system was being implemented in the designated centre for the formal supervision of staff based on re-structuring within the larger organisation.

A sample of four staff employment files were reviewed on this inspection. They were found to contain the information as required by Schedule 2 of the regulations in each case. All registered nursing staff were recorded on the active register of nurses in Ireland. There were no volunteers working in the centre.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

As stated in outcome 17, inspectors reviewed a sample of staff files and confirmed that they contained all of the relevant information as required by Schedule 2.

The designated centre maintained a directory of residents which contained the pertinent information as required by Schedule 3 of the regulations and recorded temporary absences by residents as appropriate.

Inspectors found that a number of policies did not adequately inform practice or were not available on the day of inspection as required by Schedule 5 of the regulations. Inspectors reviewed the policy informing management of residents' communication and found that it did not adequately inform the needs of residents in the centre. The nutrition policy available to advise staff was not adequate as it did not advise on all aspects of nutrition including specialised dietary management for residents in the centre with complex nutritional needs. Other policy documentation medication management also required review. A smoking policy was not available in the centre on the days of inspection. One resident engaged in smoking.

A policy document advising on residents' access to education and training was not available.

Most records as required by Schedule 4 were maintained in the designated centre, inclusive of all accidents and incidents in the designated centre and a record of all charges to the resident. However, personal property lists were maintained however a sample reviewed by inspectors were not dated as discussed in outcome 1 and required by schedule 3 of the regulations.

While protocols were in place for use of PRN (as required) chemical restraints, administration of same was not clearly reflective of the National Policy 'Towards a Restraint Free Environment' and record documentation required review to demonstrate use as a last resort following adequate trialling of alternative means to de-escalate negative behaviours as required by schedule 3, paragraph 3(n) of the regulations

As part of the application to register the designated centre under the Health Act 2007, the provider evidenced to the Chief Inspector that there was adequate insurance in place against accidents or injury to residents.

Residents' personal documentation was protected and securely stored in the designed centre. Records were easily accessible. A policy document was available to inform record keeping and management.

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:

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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 Health Service Executive
Centre ID:	OSV-0002454
Date of Inspection:	29 June 2015
Date of response:	02 October 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:

Residents were not provided with the means to safely lock their bedroom doors for their privacy if they wished.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

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

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

All Residents are now provided with the means to safely lock their bedroom doors for their privacy if they wished.

Proposed Timescale: 28/08/2015

Theme: Individualised Supports and Care

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

Arrangements were not in place to ensure advocates who would support residents were known to them.

2. Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

Arrangements are now in place to ensure advocates who would support residents are known to them. A representative from the national advocacy services has visited the unit on the 24.08.15 to meet with residents and a plan visit is currently being scheduled.

Proposed Timescale: 24-8-2015 and on going

Proposed Timescale: 24/08/2015

Theme: Individualised Supports and Care

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

Records provided to the inspector did not provide sufficient evidence that complaints had been promptly investigated, what actions had been taken and if complainants were satisfied with the outcome and were informed of the appeal process.

3. 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:

Complaints records were reviewed and a system put in place to demonstrate investigations if necessary and actions taken. This also includes the documented

response from complainants in relation to their satisfaction

Proposed Timescale: 24/09/2015

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:

Annual reviews of residents' personal plans were not multidisciplinary.

4. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

An invitation will be extended to all members of the multidisciplinary team for personal centred plan meetings. The next scheduled annual personal centred plan meeting is on the 12-10-2015

Proposed Timescale: 12-10-2015 and ongoing

Proposed Timescale: 12/10/2015

Theme: Effective Services

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

Goals developed for some residents did not maximise their full potential in achieving their wishes.

5. Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

Goals identified for a number of residents are currently being reviewed and new goals developed to maximise resident's full potential.

Proposed Timescale: 05/10/2015

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:

A loose key was provided in the vicinity of some fire exit doors, there was potential for misplacement in the absence of break glass units to ensure access to a key at all times.

A fire door located in a corridor was not operational with a push to open method due to a fitted latch mechanism. This finding could potentially compromise evacuation.

6. Action Required:

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

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

All fire doors have had thumb locks installed to allow easy access in event of a fire. Fire officer contacted and visited on site on the 9-7-2015 to view fire door located in corridor. Engagement mechanism demonstrated to all staff.

Proposed Timescale: 09/07/2015

Theme: Effective Services

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

Times of fire drills were not consistently recorded to demonstrate that fire drills were conducted to reflect the conditions that would be present both at day and night including the number of staff on duty and the location of residents at various times.

There was inadequate information to inform evacuation of a resident at night when one staff member was on duty, who presented as reluctant to leave during fire drills.

Arrangements for reciprocal support with another neighbouring community house, in the event of an evacuation being required during the night was not evidenced in the fire drill information. These arrangements were not explicit or adequately risk assessed to ensure residents in the designated centre were adequately supervised in the event of the one staff member on duty in the designated centre providing support to a neighbouring designated centre in the event of an evacuation being required.

7. Action Required:

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

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

Times of fire are now recorded to demonstrate that fire drills were conducted to reflect the conditions that would be present both at day and night including the number of staff on duty and the location of residents at various times. Last recorded fire

evacuation took place on the 06.09.15

All staff has now been informed to include adequate information as per risk assessments for those who present reluctant to leave during fire evacuation.

Two staff are currently on night duty within the centre should an evacuation be required.

Proposed Timescale: 06/09/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Administration of PRN (as required) chemical restraint was not clearly reflective of the National Policy 'Towards a Restraint Free Environment' and required review to demonstrate use as a last resort following adequate trialling of alternative means to dissipate negative behaviours.

8. 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:

Protocol has been developed for the administration of PRN medication on the 4-9-2015

Proposed Timescale: 04/09/2015

Theme: Safe Services

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

All members of a regional safe-guarding team had not been established to support the HSE National Safeguarding policy requirements and as such implementation of the policy into practice was hindered in the absence of clear referral and support pathways.

9. Action Required:

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

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

In the absence of the HSE safeguarding and protection team been established and in consultation with the principal social worker who has responsibility for the over-seeing

of these protection teams, a clear referral and support pathway has been identified and is now operational.

Proposed Timescale: 08.09.15 and ongoing

Proposed Timescale: 08/09/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Some residents' personal goals required review to ensure they were meaningful and developmental.

10. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

Goals identified for a number of residents are currently being reviewed and new goals developed to maximise resident's full potential.

Proposed Timescale: 04/10/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Referral to some allied healthcare professionals for assessment was not adequate.

11. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

Referrals have now been made to the appropriate healthcare professionals for assessment.

Proposed Timescale: 01/07/2015

Theme: Health and Development

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

The interventions prescribed in care plans to meet the needs of residents did not adequately inform practice.

Although reviewed by medical consultants, some residents were not referred for review by medical consultants specialising in the care of their medical condition.

12. 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 referral has now been made in relation to one resident to the appropriate medical consultants specialising in the care of their medical conditions.

Proposed Timescale: 01/07/2015

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 pharmacist did not complete medication audits as part of their obligations and as required by the regulations.

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13. 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:

Pharmacist contacted and will visit onsite and complete medication audit on the 29-9-2015.

Proposed Timescale: 29/09/2015

Theme: Health and Development

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

in the following respect:

The inspectors found that a resident was prescribed for a medication they did not require as confirmed by staff.

The inspector witnessed an incident of pre-signing for medication administration for a resident

14. 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:

All medication practices within the designated centre have now been reviewed in line with policy.

All nursing staff has completed the online medication management training course. In addition to this one staff nurse is scheduled to attend a medication management training day 14-10-2015.

Proposed Timescale: 14/10/2015

Theme: Health and Development

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

While, weekly checks were completed on medication stock in the centre, the inspectors found that a medication still in stock was expired since December 2014.

15. Action Required:

Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

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

All medication practices within the designated centre have now been reviewed in line with policy.

Proposed Timescale: 20/07/2015

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 person in charge was not a full-time position in the designated centre.

16. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

The person in charge will be in a full-time position in the designated centre from the 30-9-2015.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

A robust system was not in place to monitor the quality and safety of care and the quality of life of residents

17. 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:

A system has been put in place to monitor the quality and safety of the services. Action plans have now been developed to clearly identify any deficits found in the Audits. This action is ongoing.

Proposed Timescale: 30.09.15 and ongoing

Proposed Timescale: 30/09/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

Some areas of the service required review to ensure the effective delivery of care and support in accordance with the statement of purpose.

18. 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:

The person in charge will be in a full-time position in the designated centre from the 30-9-2015.

Proposed Timescale: 30/09/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

A review of staffing levels and skill mix as found at night was required to ensure the needs of residents could be met with regards to safe evacuation of residents in the event of a fire with one staff member on duty.

19. 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:

One Nurse and One care attendant on night duty x 7. In addition to this and in the event of a fire evacuation reciprocal support can be sought from the neighbouring community house and a protocol has been developed and is located in the fire box at the front door.

Proposed Timescale: 01/10/2015

Theme: Responsive Workforce

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

Staff education on menu planning for residents with specific dietary needs required further development.

20. 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:

A dietician is assessing all residents on the 15.10.15.

The provision of staff training in relation to all diets will be delivered on the 24.10.15

Proposed Timescale: 24/10/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Some policies were not available on the days of inspection or contained inadequate information to inform practice.

21. 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:

All policies identified, Nutrition, Communication, Challenging behaviour, Education and Training and the Admissions and Discharge inclusive of temporary absence are currently been reviewed.

Proposed Timescale: 30/10/2015

Theme: Use of Information

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

Not all records as required by schedule 3 of the regulations were maintained.

22. 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:

Personal Property inventory is now dated as required by schedule 3 of the regulations.

Proposed Timescale: 01/07/2015

