**Health Information and Quality Authority**
**Regulation Directorate**

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

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

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|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by Health Service Executive |
| **Centre ID:** | OSV-0003359 |
| **Centre county:** | Co. Dublin |
| **Type of centre:** | The Health Service Executive |
| **Registered provider:** | Health Service Executive |
| **Provider Nominee:** | Paudie Galvin |
| **Lead inspector:** | Deirdre Byrne |
| **Support inspector(s):** | Anna Doyle; Michael Keating |
| **Type of inspection** | Announced |
| **Number of residents on the date of inspection:** | 23 |
| **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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 06 October 2015 09:30 | 06 October 2015 20:30 |
| 07 October 2015 09:30 | 07 October 2015 15:00 |

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

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

**Summary of findings from this inspection**

This registration monitoring inspection was announced and took place over two days. It was the centre's second inspection by the Health Information and Quality Authority (the Authority). The designated centre is operated by the Health Service Executive (HSE). The purpose of the inspection was to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

During this inspection, inspectors met with many of the residents, family and staff

members, observed practices and reviewed documentation. Questionnaires from relatives and residents submitted as part of the inspection were also read. These were reviewed and are referenced in the report.

The designated centre comprises of five bungalows (houses in the report) where residents lived. The houses are located in a campus-style gated residential setting in a suburban area. The centre may accommodate up to 24 persons, and there were 23 residents living in the centre at the time of the inspection.

The person in charge was present throughout the inspection. A management team that oversees the running of the centre includes the director of service (the provider nominee), director of nursing, person in charge and a clinical nurse manager 3 (CNM). The management team attended the feedback meeting at the end of the inspection.

As part of the application for registration, the provider was requested to submit relevant documentation to the Authority. However, confirmation of planning compliance and payment of the registration fee had not been submitted. The provider nominee assured inspectors this information would be submitted promptly following the inspection for the application to register the centre.

Inspectors found areas of non-compliance over some outcomes monitored. These related to outcomes on social care needs, healthcare needs, medication management, rights and consultation with residents, workforce, the monitoring of risk, the admissions process to the centre and record keeping.

Furthermore, aspects of the physical layout of the some units required improvement to ensure the dignity of privacy of residents was maintained. One unit required reconfiguration to ensure the needs of the residents were met.

There was evidence of good practice across most of the outcomes monitored. Residents were familiar with the staff, who in turn were knowledgeable of the residents' social care needs. Staff were observed to interact and speak to the residents in a respectful and dignified manner. Residents were consulted with and there was a complaints process in place. There were systems in place to safeguard and protect residents, which staff were knowledgeable of. Residents and families reported they were happy with the service and that the staff were kind, patient and respectful of their needs.

The actions  from the previous inspection report were followed up. Inspectors found 15 of the 22 actions were addressed, two of the remaining actions in progress, and five were not completed.

The action plans at the end of this report identifies the outcomes under which improvements are required.

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

**Outcome 01: Residents Rights, Dignity and Consultation**
*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
There were good systems in place to consult with residents and procedures to ensure residents' privacy and dignity was maintained, however improvements in relation to the management of complaints and residents' personal finances required improvement.

Inspectors found residents were consulted with and individual unit meetings were held on a weekly basis. Inspectors read minutes of a sample of house meetings minutes, and it was evident that residents were included in the running their home. Although inspectors read that a number of issues were raised by the residents there was no feedback or update provided. For example, requests for new furniture or the decoration of houses.

While systems were in place to ensure residents' privacy was maintained, improvements were required for residents who shared bedrooms. Bedrooms were provided with curtains and blinds, and residents had keys to their bedroom doors. However, screens were not provided in two bedrooms between residents' beds to maintain residents privacy and dignity. Locks were provided on the shower and toilet doors.

There was a complaints policy and procedure in place. There were accessible versions of the procedure in pictorial format displayed in each house in the centre. Inspectors spoke to one resident who was familiar with the policy. She informed them that it had been discussed at the unit meetings. While the procedures reflected the details of the complaints officer along with photos of the person, it was not centre-specific. For example, the complaints officer was not based in the centre, and the person in charge

usually managed compliants. This was discussed with the provider nominee and the person in charge who agreed to make relevant changes.

A complaints log book was read that recorded complaints for the centre. There were good practices in the documentation of complaints however, the investigation and action taken was not documented. The satisfaction of those making complaints was also not recorded. A new complaints form was shown to inspectors which will replace the log book and address the gaps in the current process.

There was a policy in place to provide guidance on the care of residents' property and finances. However, residents did not have their own bank account. For example, residents' monies such as pensions and disability allowance were paid into a centralised Health Service Executive bank account. Inspectors discussed this with the provider and person in charge. This was an action at the previous inspection and was not addressed.

The handling of residents' day to day monies was managed in the main office of the centre. Inspectors reviewed the practices in place for handling the transaction of residents' monies that were held in safekeeping. Inspectors were satisfied that the systems in place to safeguard the finances of residents were robust. The action from the previous inspection was complete and two signatures were provided for each transaction. Inspectors found only a small number of designated persons had permission to access residents' monies. However, residents may be restricted from accessing their own money at weekends and certain days of the week if these staff were not working.

There was information on an independent advocacy service displayed in each unit for residents to see. A social inclusion officer had commenced visits to the centre to meet with the residents independently at a group called the 'speak easy' and minutes of these meetings were read.

Residents could make choices about their daily lives such as when to go to bed, what food to eat and how to spend their free time. However, residents told inspectors that they had not been a holiday in a number of years and would like to go on one. This was discussed with the provider nominee who outlined internal discussions regarding this.

Residents were supported and encouraged to take responsibility for personalising their own bedrooms. A list of residents' possessions was kept on their personal file.

**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 satisfied that the person in charge ensured the communication support needs of residents were met.

There was a policy on communication with residents. Inspectors saw residents' communication needs were reviewed, as part of an annual assessment. Where residents were non verbal there were 'communication passports' developed that reflected the residents' needs, and the practices observed on inspection. Also, inspectors reviewed a summarised and pictorial version of one resident's daily activities.

There was a range of methods utilised to improve residents' means of communication. For example, a 'needs and feeling' communication sheet was used for some non-verbal residents. This technique was used to enhance staff knowledge of what the resident was trying to communicate. For example, correlating certain actions with emotions the resident may be experiencing at that time, such as feeling happy, sad or hungry.

Inspectors observed staff who spoke with and listened to residents in a patient, quitet, kind and respectful manner. Pictorial aids were used to aid communication with non-verbal residents'. For example, the complaints policy included pictures of those to whom residents could complain to; a residents guide contained photos to describe the service were provided; a daily programme and menu were in pictorial format. The information was also displayed on a communication board in each of the houses communal sitting room and dining rooms which helped to aid communication with residents.

There were televisions provided in each communal area, and residents had a television in their bedroom. Some residents had their own music system and others their own radio. A number of residents told the inspectors that they had their own computer. For example, one resident talked about a new tablet she had, and the games she would play on it. There was Internet access available also. There were telephones accessible to residents in the five houses.

**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:**
Residents were supported to develop and maintain personal relationships and the residents were encouraged to develop links with the wider community.

Inspectors found there were links being developed with the local community. A number of residents attended courses and classes in a local college and one resident told inspectors about a course on reading and writing he was attending. Other residents were attending computer classes in the area. One resident helped out in the local parish church. Some of the residents were part of a local 'men's shed' which organised activities for older men. There was scope to integrate residents further into the community by exploring options for skills development, specifically residents who may eventually transition out of the centre.

While some residents were involved in activities as outlined above, many of the residents were still dependent on life in the main campus, and spent most of their day in and around their home and the grounds of the campus. There had been day service facilities provided on the campus grounds which were no longer operating at their full capacity. However, the provider had endeavoured to address this, and rooms in the building were being used. For example, inspectors met residents who were attending baking classes, the gym and music therapy. Inspectors were also informed that discussions were taking place in relation to re-developing the day service.

There was a visitors policy for the centre that placed no restrictions on visitors. This was confirmed by residents who told inspectors family or friends could visit them anytime. A family member confirmed to inspectors that they could visit their loved one whenever they needed to, and always felt welcome in the house by staff. While there was plenty of communal space for residents to meet family and friend, there was no private room in some of the units for residents to receive visitors.

Residents explained how they were facilitated by staff to visit their family home. One resident told the inspectors how she visited her sister's home at weekends and another resident went on holidays with her family. Residents who had chosen their families to be involved in their care had been invited to attend the residents' recent annual review.

**Judgment:**
Substantially Compliant

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

**Theme:**
Effective Services

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

**Findings:**
Inspectors found the provider ensured admissions and discharges to the service were planned and timely, and each resident had an agreed, written contract of the service they were being provided.

Since the last inspection, each resident had a contract of care that sets out the services provided. The contracts of care were signed by the resident or their representative where required. The contracts also included the fees to be charged.

There were policies and procedures in place for admitting residents, including transfers, discharges and the temporary absence of residents. There had been no recent admissions of residents to the centre. The person in charge outlined the admissions process which was reflective of the procedures in the Statement of Purpose.

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

**Findings:**
Inspectors found improvements were identified in the completion, review and involvement of residents in their personal plans. The provision of, and access to, opportunities to participate in meaningful activities appropriate to residents' interests also required improvement.

Overall, the residents' welfare and wellbeing was maintained by a good standard of care and support by staff who were familiar with their social care needs. The residents were assessed as having a mild to severe disability. Inspectors read a sample of eight

residents' personal plans. A comprehensive assessment of residents' needs was completed annually. It is called an 'individual client assessment'. The assessment reviewed the residents' health, emotional, safety and support needs. The assessment informed residents' personal care plans. There was a key worker assigned to each resident who supported them and created their personal plans, along with nurse overview.

However, the documentation and review of the personal plans required improvement. The residents' personal plans were contained within three folders. While improvements had taken place since the last inspection, and the amount of information contained in each file had been reduced, this was still work in progress. Due to the large volume of information in the folders, inspectors found it difficult to identify the most up-to-date information on each resident. For example, health-related and risk-based issues were not at the front but at the back of each file. In addition, pertinent information regarding residents' health-care needs were not maintained an accessible location or within residents' file and was therefore inaccessible to staff. This is discussed further under Outcome 18.

The development of residents' personal plans required improvement. The plans read were not holistic and focused on limited aspects of residents' lives, such as their health-care needs. For example, promote bowel function, skin care regimes, mobility issues. While there were daily updates completed by staff against these goals, a comprehensive review to ascertain how effective these goals had not been carried out. Therefore there was no evidence that personal plans impacted positively on the lives of the residents. This had been an action at the previous inspection and was not completed adequately.

The personal plans were completed annually and reviewed once a year with the residents' or their relatives' input. While there were multidisciplinary team meetings, there was no evidence that residents' goals were discussed at these meetings. In addition, the residents were not provided with copies of their personal plans in an accessible format. All of these matters were discussed with the person in charge and the provider following the inspection, who acknowledged improvement was required.

While residents told inspectors about their lives and they were aware of files kept for them, there was inconsistent evidence that the residents were involved in or consulted with in the creation of the personal plans. An annual meeting took place with the residents which their family or representative were invited to attend however, it was not clear how the residents' feedback was considered as part of the review. From discussions with the person in charge, nursing staff had completed training in the development of personal plans however, on going improvements were still required as evidenced above.

Inspectors reviewed a sample of residents' health-care plans. However, some care plans read did not consistently guide practice. For example, the dysphagia guidelines for one resident were generic and not person-centred. Additionally, care plans were not developed for all residents' identified needs, for example, falls, dementia, dysphagia and mental health issues.

The residents' welfare and wellbeing was maintained by an good standard of care and

support, by staff who were familiar with their social care needs. Since the last inspection the provider nominee had taken action in the provision of activities for the residents. As reported in Outcome 3, activities in the campus for residents included music therapy, siel bleu ( a therapeutic programme of exercise done to music), exercise classes, baking classes, one-to-one time, occupational health sessions. In addition, some residents were taking part in more activities outside the campus, that included going on hikes, walks, cinema trips, and to their respective classes and courses. Inspectors noted that the majority of residents remained in the centre during the day. There was a need for more exploration of their social care needs being met within the campus. The provider and person in charge acknowledged improvements were required, and inspectors were informed there were plans in place address this.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective Services

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

**Findings:**
Overall, the design and layout the designated centre were in line with Statement of Purpose. However, aspects of the centre do not meet the individual and collective needs of the residents and the requirements of the regulations. The centre is located in a residential campus, and comprises of five detached bungalows. The bungalows (called houses) are located beside each other, divided by open plan gardens with paved pathways interconnecting them. There are good public transport links with a bus stop close to the centre.

Houses 1 and 5:

These houses are similar in design and layout. There is occupancy for five residents in each, and five single bedrooms are provided. One resident showed inspectors her bedroom. She had her own key to the bedroom which she unlocked to show inspectors. The bedroom was nicely decorated, with photos of the resident with her friends and family. The resident had many of her personal possessions in the room, which was of suitable size and provided adequate space and storage for clothing and or personal possessions. There was a double bed. In both houses, there is a communal shower room, bathroom and toilet. A separate staff toilet was provided. While all areas were

nicely decorated, the bathrooms were quite clinical in their appearance. The large open plan dining-living room was nicely decorated with a small fireplace and comfortable couches and seats. It was noted the material on some couches were worn and required replacement. There was suitable storage for equipment provided. The kitchen was provided with cooking facilities and equipment. There are ramps into the centre at the front entrance. A shared communal garden is directly accessible to residents from the houses.

Houses 2 and 3:

These two houses are similar to units 1 and 5. The houses have an occupancy of six residents. There are four single bedrooms and one twin room in each house. However, inspectors were not satisfied there was sufficient private and communal space for the residents in the twin bedrooms. The beds were less than two feet apart, there was no screen for privacy provided and there was limited space to personalise the area around beds and display personal possessions and to have visitors at the same time. There was very little space for one resident in a twin room to personalise around their bed due to the lack of space. Inspectors spoke to residents who told them that they would like to have their own bedroom. This was discussed at feedback and it was acknowledged that improvements were required.

House 4:

This is also similar to all four houses above. There are two residents living in the house. To ensure residents' needs are met, there are presently no new admissions being made to the unit. The residents have a single bedroom and there is a small private sitting room also. However, the design and layout of the house did not presently meet the residents' assessed needs. For example, one resident was being woken up during the night by the other resident, which impacted on their quality of life during the day. Internal reconfiguration works in the house would benefit both of the residents. These matters were discussed with the person in charge during the inspection who acknowledged that improvement was required.

There were two wooden smoking shelters with seats provided. Residents used these areas when they wished to smoke. However, they were not maintained in good repair for example, the wood was showing signs of decay.

The interior of each of the five houses were maintained to a good standard of repair, cleanliness and hygiene. Inspectors were informed that the staff carry out the cleaning procedures and suitable cleaning equipment was provided. An external cleaning company also provided additional support during the day. There were laundry facilities in each house for staff and residents if they wished to launder their clothes.

There was assistive equipment provided to support and assist residents. For example, a hoist, wheelchairs and mattresses. Inspectors reviewed service records that confirmed the equipment had been serviced and was in good working order.

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

**Findings:**
Inspectors found there were systems in place to promote and protect the health and safety of residents, staff and visitors to the designated centre. However, aspects of risk management and fire safety required improvement. The actions from the previous inspection had been addressed.

There were a suite of risk management and incident investigation policies. Inspectors found the risk management policy met the requirements of the regulations. However, it was not fully implemented in practice to ensure all potential risks in the centre had been identified. For example, an oxygen cylinder located in one house had not been risk assessed and controls developed. The risk assessments for residents who smoked required review as they did not give guidance to staff on the control measures in place.

There was a risk register for the centre which included clinical and environmental risk along with the risk rating and control and measures in place to control them. However, the register also included clinical and behavioural risks associated with individual residents that contained personal information, that were not located in the residents' files. This is discussed in Outcome 5.

Inspectors found incidents that occurred in the centre were documented, and the person in charge and CNM reviewed these. This was an improvement from the last inspection. Incident reports were also submitted to the HSE for further review and analysis. However, the learning and improvement to be brought about from incidents was not recorded, for example, medication errors.

A health and safety statement was seen by inspectors. There was emergency evacuation plan in place. Each resident had a personal evacuation emergency plans (PEEP) that was reviewed and kept up to date.

There were infection control procedures in place. There were hand gels present throughout all units in the centre and hand-washing guidelines were displayed for staff.

There were systems in place for the management of fire safety. Inspectors reviewed records that confirmed all staff had received training in fire prevention and the use of extinguishers. While most staff were familiar with the procedures in place, staff were unsure of the procedures in one house. This was brought to the attention of the person

in charge during feedback.

Inspectors read the records of fire drills carried out that confirmed they took place at minimum six-monthly intervals, and included night drills. The records included the outcomes at each drill, and any action to be followed up. Inspectors spoke to one resident who told her about the fire drills and that she took part in them too. The staff completed daily, weekly, monthly and quarterly checks of safety equipment and alarms and exits. These were both improvements from the last inspection.

Records were read and confirmed that fire fighting equipment was serviced regularly at frequent intervals. There were suitable containment systems in place, with fire doors provided on all doors of the house. Fire procedures were displayed prominently throughout the centre.

**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:**
Inspectors were satisfied that the provider had measures in place to safeguard and protect residents from abuse; had ensured systems were in place to promote a positive approach to behaviours that challenge; and the management of restrictive practices was in line with national policy. The actions from the previous inspection were addressed.

There were policies on and procedures in place for the prevention, detection and response to abuse that were comprehensive and reflected the Safeguarding Vulnerable Persons at Risk of Abuse HSE National policy and procedures, December 2014. Inspectors spoke with staff who were familiar with the types of abuse and how they would respond if an allegation of abuse was made. The staff had completed up-to-date training in safeguarding of residents, and records read confirmed this. The provider was also implementing the newly revised safeguarding policy and all staff were attending training currently, with eight more staff due to attend training in November 2015.

The person in charge, CNM and the director of nursing were familiar with the procedures to follow if an investigation into an allegation of abuse was required. The director of nursing was the designated person nominated in the organisation to oversee the investigation of allegations of abuse. The person in charge was familiar with her role and responsibilities in relation to these procedures. She was supported by the CNM and the director of nursing in the event of an allegation being made.

Each resident had an intimate care plan that was incorporated into their personal plans. The plans provided clear guidance and reflected the residents' wishes.

There were number of residents who presented with responsive behaviours that required positive support interventions (behaviours that challenge). Inspectors reviewed behaviour support plans in place for three residents'. The plans were detailed documents and they provided clear and comprehensive guidance to staff on the supports in place for each resident. The plans were developed by an specialist referral that included a clinical nurse specialist, in conjunction with an external psychology team, who had recently reviewed each of the residents along with the support plans. There was good access to the internal and external psychology teams, and also internal psychiatry services if required. There were letters and minutes on residents' files of the regular input from these departments.

Inspectors discussed the plans with staff, who were familiar with the supports in place and the strategies that would be carried out. Staff have reported a reduction in incidents in the centre since the review of the plan and the addition of supports. Overall, they reported positive outcomes for of the residents in two units as a result. However, the documentation of incidents reports required improvement. For example, up to five separate reports were completed for each incident, and on reviewing these, they contained inconsistent information which may lead to an unclear account of what had occurred. While staff completed evidence-based tools such as the antecedent behaviour consequence (ABC) charts, the forms did not provide room for staff to record incidents at night time, which may result in important information not being recorded. This is discussed in Outcome 18.

There was little use of restrictive practice carried out in the centre, and where used there were safeguarding measures in place to ensure it was utilised in accordance with the National Policy 'Towards a Restraint Free Environment'. There was a policy that provided guidance to staff. Where restrictive practices were in place, and depending on the type of practice (chemical or mechanical or a human-rights restriction) these were reviewed and the use and rationale for continuing same.

**Judgment:**
Compliant

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

**Theme:**
Safe Services

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

**Findings:**
Inspectors found that the person in charge and staff had maintained records of all accidents and incidents that had occurred in the centre.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date where required by the regulations, incidents had been notified to the Chief Inspector by the person in charge.

**Judgment:**
Compliant

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

**Theme:**
Health and Development

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

**Findings:**
Inspectors found residents had opportunities for new experiences, social participation, education and employment.

Residents were encouraged to take part in a range of activities, both in the centre, and in their respective day services. A number of residents who attended courses to enhance their development for example, reading and computer classes. Inspectors spoke with one resident attending the reading classes who described the work involved and preparation for each class.

A bakery class took place in the centre and inspectors met the staff who facilitated this. It was beneficial for residents to broaden their skills and become more independent in the kitchen. Inspectors met some of the residents' during one class, who were making scones and washing up the dishes.

Inspectors also spoke with some residents about the activities they enjoyed, their options and routines, and the things that were of interest to them. Residents told

inspectors about their social lives, and shared experiences of recent events such as going on trips to shops with family members, to coffee shops in Wicklow, the local parks.

**Judgment:**
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):**
No actions were required from the previous inspection.

**Findings:**
There were systems in place to support residents to achieve best possible health however, the assessment process and ensuring timely responses to meeting residents identified needs required improvement.

The arrangements for the identification and assessment of residents' health-care needs required improvement. An assessment called an 'individual client assessment' was completed annually and it gave a general overview of the residents' healthcare needs. However, evidence-based health-care assessment tools were not utilised to assess residents' health-care needs, apart from assessing falls risks.

There was no manual handling assessments completed for one resident who required assistance mobilising with a hoist. The resident was identified as a risk of falls, yet there were no specific guidelines on the level of support required during the day and in the evening time.

Where specific health-care needs had been identified, care plans were developed. However, these were not consistently developed for all residents' identified needs. For example, falls, epilepsy and mental health. The health-care plans for residents did not consistently guide practice, for example, dysphagia and recurrent infection. There was irregular review or updating of care plans as the residents' needs changed. These matters are discussed in Outcome 5. Inspectors brought these issues to the attention of the person in charge and provider nominee during the feedback.

While there was nursing care and support provided in the centre over a 24-hour period, inspectors found a timely response to residents' care issues in the centre required improvement. Inspectors met one resident who was lying on a couch in their home as they were feeling unwell. The nurse on duty was asked about the resident's health status. Inspectors were told the resident felt unwell regularly and it may be caused by

certain medications. The resident had blood tests taken recently to investigate this further. However, the nurse was unable to provide any follow up information or an update on the results of the blood tests. Inspectors were also told it was the clinical nurse managers' role to follow this up. These concerns were brought to the attention of the person in charge, who took prompt action and later assured inspectors and gave a clear update of the resident's health status.

The completion of nursing notes required improvement. Inspectors read a sample of nursing notes, and they were not completed on a daily basis. For example, there were gaps of a number of days between entries.

Inspectors were told by staff and residents that there was access to a general practitioner (GP), who visited the residents in the centre. Records of appointments with the residents were maintained. The GP was present in the centre most days of the week, and an out-of-hours on call service was available. Where residents wished to have the services of another GP of their choice, this was facilitated.

Documentation read and information from staff confirmed that residents accessed other health professionals such as the physiotherapy, occupational therapist, dietician and speech and language therapist services when required. There was evidence of referral and follow-up letters, along with recommendations on the residents' files.

There were procedures in place for end-of-life care. There were no residents approaching end of life in the centre at the time of the inspection, but the person in charge and CNM had met all families to discuss residents wishes and preferences.

There were good practices in place for residents to make healthy living choices around food. The residents' meals were prepared by the staff in each of the five houses. The menu was decided at the weekly house meetings and it was displayed in the dining room. At this inspection, residents' were not observed having their evening meal. Inspectors did see plenty of fresh food ready to be prepared every day. The fridge and cupboard were stocked with plenty of fresh fruit and vegetables.

The residents were supported to prepare snacks or cups of tea. As reported in Outcome 10, some residents attended bakery classes to develop skills in preparing snacks and small meals. A number of residents had specialised dietary requirements and other residents were on modified textured diet. The staff were familiar with the recommendations from the speech and language therapist. These were located in each residents' file. Although an area of improvement regarding the completion of care plans is outlined above.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Health and Development

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

**Findings:**
There were written operational policies and procedures relating to the ordering, prescribing, storing and administration of medicines to residents. However, significant improvements were identified in the implementation of the policy and practices in the centre.

Inspectors found medications were securely stored in a locked press. However, this required improvement as the press could be accessed by all staff. For example, staff not involved in the administration of medications also had access to other items stored within the medication press.

A sample of residents' prescription and administration sheets were reviewed during the inspection. Inspectors discussed medication practices with one nurse who was familiar with the policies in place. However, inspectors observed an omission of medication for one resident from that morning's medication pack. This was addressed when brought to the staff nurse's attention.

Medication errors were reviewed by inspectors and a recurring theme was highlighted regarding omissions. The person in charge informed the inspectors that they had met with the pharmacist to review practices. However, there were no documented recommendations made and therefore it could not be determined what improvements if any had been made. See Outcome 7.

The process of storing unused medications required improvement. For example, inspectors found a number of medications had not been returned to the pharmacy and were not segregated from other medications.

There was no system of labelling containers of medication with a use-by-date once opened. For example, prescribed creams were not labelled with the start date of treatment and therefore it was difficult to determine the expiry dates for creams. This is discussed in Outcome 18.

Compliance aids were labelled to allow staff to identify individual medications, however, on the day of inspection; inspectors noted one medication that was not identifiable and inspectors were unable to identify if the correct medication had been dispensed from the pharmacy. This was followed up by staff with the pharmacist on the day who took immediate action to rectify the situation.

Residents' medications were regularly reviewed by their GP on a three-monthly basis. However, the review date was entered in the prescription sheet under the date the treatment started, which could cause confusion to staff who were unaware of how long

residents were on a medication.

There were no residents self-medicating in the centre. While there were procedures in place to guide staff, and inspectors spoke to one resident who was knowledgeable of medications prescribed, this had not been explored as an option for any of the residents. The pharmacy also provided a counselling for residents around medications they are prescribed. This option had not been explored by the provider.

**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:**
Inspectors found there was a written Statement of Purpose that met the requirements of the Schedule 1 of the regulations.

The Statement of Purpose accurately described the service and facilities that are provided in the centre.

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

**Findings:**
Inspectors were satisfied that the centre was managed by the clinical nurse manager 2 (CNM2) who was suitably qualified, experienced and fulltime in her role. She will be referred to as the person in charge. She fully participated in the inspection process and demonstrated appropriate knowledge of the regulations. The person in charge was new to the role and the organisation since July 2015, and it was evident that the residents were familiar with her. She was observed to spend time talking and interacting with residents.

There was a person nominated to deputise in the absence of the person in charge. The CNM3 supported the person in charge and worked three days a week in the centre. Both persons were interviewed during the inspection and were aware of the regulations and their responsibilities therein.

As reported earlier, the centre is operated by the HSE and there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision of the service. The management team included the provider nominee (director of services), director of nursing, the person in charge and CNM3. Inspectors found there were governance and management arrangements in the the centre. However, improvements were required to ensure an adequate level of supervision of care and practice was provided. For example, as outlined in Outcomes 5, 11, 12 and 17, improvements are required in order for the centre to be fully in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) with Disabilities) Regulations 2013.

The lines of authority in the centre on a day-to-day basis and the role of the person in charge also clarification. For example, some staff told inspectors they were in charge, although the person in charge was in the centre. Inspectors discussed the meetings attended by the person in charge and saw records of monthly scheduled and minuted meetings between the management team. There were weekly staff meeting held by the person in charge with the staff.

There were systems in place to ensure that the service provided were safe, appropriate to residents' needs, consistent and effectively monitored. The director of services together with the director of nursing had conducted a number of six-monthly unannounced visits of the three houses. The reports from these visits were read by inspectors, and they covered a range of standard areas including hygiene, infection control and security. The report also included areas for improvement and issues which require follow up, by whom and within what time-line. However, improvements had not yet to be fully brought about to address all of the issues identified in the audits and by inspectors during the inspection, and which are identified in this report.

There was an annual review of the quality and safety of care and support in the centre. It had also been completed in consultation with the residents, residents representatives and staff. There report included issues raised in the process of consultation, although there was no evidence of follow through. This was discussed with the person in charge

who said she would address this. In addition, the report does not outline areas of improvement and issues to be followed up on.

The provider had been requested to submit an application to register the centre by the Authority. There was some outstanding information: confirmation of planning compliance and evidence of payment of application fee. This information is required before a recommendation to grant registration can be made by the Authority.

**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:**
The provider nominee was aware of the requirement to notify the Chief Inspector of any proposed absence of the person in charge for a period of more than 28 days.

The provider nominee had appropriate contingency plans in place to manage any such absence. There were satisfactory arrangements in place through the availability of a CNM3 to cover absences of the person in charge. The CNM3 demonstrated a clear understanding of her role and responsibilities under the regulations if required to deputise for the person in charge.

**Judgment:**
Compliant

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

**Theme:**
Use of Resources

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

No actions were required from the previous inspection.

**Findings:**
Inspectors found there were sufficient resources available to meet the needs of residents however, improvements were required to ensure staff in the centre were deployed effectively to ensure residents' social care needs were met, as outlined in Outcome 5.

Inspectors found resources were not effectively deployed to support residents' individual needs. For example, during the day there were two to three staff in each house. However, inspectors were told that due to unexpected staff leave, staff were moved between houses, thus impacting on residents' social care needs. Rosters read confirmed there were up to two staff rostered in some houses at night time. There was no assessment of need completed confirming the requirement for this level of staff.

**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 inspectors found there was an adequate number of the staff to meet the needs of the residents. However, improvements were required in relation the system of supervision and the staff roster.

There was no formal system of staff supervision in the centre. This was discussed with the person in charge who said it had yet to be implemented with all staff. This had been an action at the previous inspection, and was still not addressed.

Inspectors reviewed the planned roster in place. However, the times staff were scheduled to work were not stated on the roster. Therefore if could not be ascertained what time staff started and ended their working day at. The roster did not indicate if agency staff were working and who was supervising these staff at night time. An amended version of the roster with staff hours was shown to inspectors on the second

day. It indicated there was an adequate number of staff on duty to meet the residents' needs.

Staff files were located in the centre and at an office off-site. Inspectors reviewed a sample of files in the centre at this inspection and they contained the information as per the requirements of Schedule 2 of the regulations.

There were a number of agency staff who worked in the centre. A service level agreement in place was read by inspectors. It confirmed that agency staff were recruited in line with Schedule 2 of the Regulations.

Staff training records were reviewed. There was evidence that all staff had completed up-to-date mandatory training.

There were no volunteers 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:**
Inspectors found that there were systems in place to maintain complete and accurate records and that the required policies were in place.

The written operational policies had been reviewed by the Authority prior to the inspection and were found to provide guidance to staff. Inspector found that staff members were sufficiently knowledgeable regarding these operational policies. However, the risk and medication management policy was not fully implemented in practice, as outlined in Outcome 12.

Inspectors found there were records required to be maintained for each resident. The maintenance of residents' files required improvement. Since the last inspection, the person in charge and CNM had reviewed all files and historical information had been archived, and this is acknowledged by inspectors. However, further improvement was still required. There were three folders for each resident that contained their personal information. Each folder contained large volumes of information and as a result it was difficult to ascertain residents' most pertinent support and care needs. See Outcome 5. The completion of nursing records as discussed in Outcome 11 also required improvement.

The directory of residents was up to date, and there was satisfactory evidence of insurance cover was in place. Inspectors read the residents' guide and found that it provided detail in relation to all of the required areas. This document described the terms and conditions in respect of the accommodation provided and provided a summary of the complaints procedure.

**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:***

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by Health Service Executive |
| **Centre ID:** | OSV-0003359 |
| **Date of Inspection:** | 06 October 2015 |
| **Date of response:** | 23 November 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 system of consulting with residents requires improvement.

**1. Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

**Please state the actions you have taken or are planning to take:**
• The Registered Provider has reviewed documentation relevant to consultation forums for residents a section has been included in the resident's weekly meeting template to take account of issues raised. This includes who dealt with the issue or whom the issue was referred to. The section also facilitates a signature, date and time for action/s taken.
• The new Complaints Form records the stages of the complaint investigation and feedback as to whether the outcome is to the satisfaction of the complainant.
• The Complaints policy has been revised to include the PIC as the local person to manage complaints in the first instance.
• Forum meetings will now identify that issues raised at previous meetings are dealt with or have a completion time.
• The Advocacy Speak Easy meeting minutes, which are held once a month, will be reviewed by the PIC to ensure that all areas of concern identified are addressed in a timely manner.

**Proposed Timescale:** 19/11/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no screens provided between beds in the two-bedded rooms.

**2. 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 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:**
The Registered Provider has:
• As an immediate response following inspection screens have been purchased for the two shared bedrooms.

• To meet the long term needs of 4 residents the HSE is at preliminary design stage for a house in the community to meet 4 residents' needs. Following the successful development of such a house each resident in Hawthorns will have their own room.

**Proposed Timescale:** 10/12/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were not facilitated to go on holidays.

**3. Action Required:**
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

**Please state the actions you have taken or are planning to take:**
• The HSE Finance Department have outstanding issues in relation to previous holidays and instructed that no holidays are to take place until these issues are resolved.
• The Registered Provider is engaging in ongoing dialogue with HSE Finance Dept. in the resolution of this matter.
• The Registered Provider has engaged with HSE Finance Dept. in developing a policy for resident's holidays that will meet the residents and HSE Finance requirements.
• The delays in the annual holidays will be discussed with residents at the Forum meetings and individually where they wish to do so.
• The HSE is at an advanced stage in the recruitment of a service administrator who will take responsibility for the oversight of the financing of the resident's holidays.

**Proposed Timescale:** 01/04/2016

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents could not access their own monies held in safekeeping on certain days of the week.

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

**Please state the actions you have taken or are planning to take:**
• The Person in Charge (PIC) since inspection has arranged that enough funding is available outside normal office hours and at weekends to meet the requests from residents for access to their money
• The Person in Charge (PIC) ensures that adherence to the safeguards in place to manage resident's finances is adhered to when accessing resident's monies outside of office hours including two signatures for each transaction through an audit process.

**Proposed Timescale:** 19/11/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents monies were paid into a Health Service Executive bank account and not paid into an account of their own name.

**5. Action Required:**
Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

**Please state the actions you have taken or are planning to take:**
• The Registered Provider will ensure that any resident that is deemed to have financial capacity will be supported to open a bank account in their own name.
• The Registered provider will ensure that any resident who is deemed not to have capacity will have their finances managed in accordance with HSE Financial Regulations.
• The resident's finances are managed in the designated centre in line with HSE Financial Regulations, however the HSE is aware that this arrangement is not in compliance with HIQA Financial Regulations.
• The Registered Provider has highlighted this anomaly to the HSE Finance department, the HSE National Office are in dialogue with HIQA re this anomaly.
• The Registered Provider is awaiting a guidance response from the HSE Finance Department on meeting compliance on our requirements in relation to governance of resident's finances.

**Proposed Timescale:** 01/05/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Complaint records read did not include details of investigation carried out, outcome, and the feedback to persons making the complaints.

**6. 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:**
• The Registered Provider has revised the Complaints Policy and Procedure to include incorporating survey responses from families and feedback from resident's weekly meetings into the Complaint structure where appropriate.

• Changes have been made to the complaints procedure to facilitate a local response and resolution to complaints/concerns from the PIC and Deputy PIC in the first instance. Where concerns are unresolved they are escalated to the Complaints/Appeals Officer for the service.

• The Complaints Form outlines the record of each stage of the complaint investigation, including the complainant and the nature of the complaint, response to complaint, to

whom it was escalated if appropriate and whether it was resolved to the satisfaction of the complainant.

**Proposed Timescale:** 19/11/2015

**Outcome 03: Family and personal relationships and links with the community**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The exploration of skills training for residents to integrate into the community required review.

**7. Action Required:**
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

**Please state the actions you have taken or are planning to take:**
• The HSE have facilitated a transition of current day services from another location to the on- site Day Activity Centre building.

• The Registered Provider has identified with the day service team that opportunities for skill sampling will be made available for residents of the designated centre.

• The PIC in consultation with day service staff will identify appropriate assessment tool/s to assist in identifying skills, interest and aptitudes' of the residents to support meaningful integration into the community and training opportunities for them.

**Proposed Timescale:** 11/03/2016

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The personal plans were not in an accessible format for residents.

**8. Action Required:**
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

**Please state the actions you have taken or are planning to take:**
• The PIC will continue to work with staff on developing more accessible information for

the residents to support their PCP's.

• The PIC will prioritise the development of accessible person centred plans individualised to each resident with a view to having 6 completed every 6 months.

**Proposed Timescale:** 11/03/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The completion of health-care plans for residents required improvement.

Care plans in place for residents' identified needs did not consistently guide practice.

Care plans were not developed for all identified needs as outlined in the report.

**9. Action Required:**
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

**Please state the actions you have taken or are planning to take:**
• The PIC and Deputy PIC have developed a new filing system/structure for more consistent, streamlined, user friendly approach to the development and evaluation of care plans across the service.

• The PIC has implemented an audit of current care plans and will ensure that there is documentary evidence of this review and a remedial action plan.

• The PIC will conduct six monthly audits of Person Centred plans to evaluate the effectiveness of each care plan in identifying the assessed needs, changes in circumstances and new developments.

• The PIC will conduct six monthly audits of Person Centred plans to evaluate the effectiveness of each care plan in the guidance of practice is consistent.

• The PIC will develop a policy on key-working to guide front line staff in their role in assessment of the care and support needs for the residents and in the development of holistic care goals which will address the identified needs of residents.'

• The PIC has implemented new Dysphagia guidelines which are individualised to each resident that requires them.

• The PIC will continue to reduce the amount of information contained in personal plans to ensure that most up to date that pertinent information regarding resident's health needs are maintained in an accessible location within the file.

• The PIC will ensure that the management team will be informed of the progress of quality improvement plans at the monthly governance meetings.

**Proposed Timescale:** 11/03/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence of multidisciplinary input into residents' personal plans.

**10. 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:**
• The PIC will ensure where residents are in receipt of MDT inputs that it is reflected in the person centred plan.

• The PIC will involve the relevant MDT professional in the PCP review.

• The PIC will ensure MDT records and reports will form part of the PCP where relevant to their ongoing goal. These will be cross referenced where applicable in others areas of care.

• The PIC will promote social integration and community access for residents in line with their personal plan goals.

**Proposed Timescale:** 11/03/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The personal plans were not holistic and mainly focused on residents' health care needs.

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

**Please state the actions you have taken or are planning to take:**
• The Person in Charge will ensure that an up to date annual assessment is completed which identifies each individual's health, personal and social care needs and which informs the development of the resident's person centred care and support plan.

• The Person in Charge will ensure that all person centred plans are reviewed three monthly to ensure that goals are developed to meet resident's lifestyle choices and needs in addition to health care needs.

• The Person in Charge will conduct a six monthly audit of person centred care and support plans to ensure that goals have positive outcomes for resident's identified social, personal and health care needs.

• The PIC will ensure that there is consistent documentation and evidence of resident's involvement and feedback in their care plan.

**Proposed Timescale:** 08/04/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plan reviews did not assess the effectiveness of the goals on residents' lives.

**12. Action Required:**
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

**Please state the actions you have taken or are planning to take:**
• The PIC will audit on a six monthly basis the Person centred plans to evaluate the effectiveness of each individualised plan in meeting the assessed needs, changes in circumstances and new developments for each resident.

• The PIC will ensure that there is documentary evidence of this review with a rationale for any changes made with a staff member assigned for its implementation.

• The PIC will ensure that recording of goals will be a part of a comprehensive review/ evaluation of their effectiveness to ensure that identified goals have impacted positively on residents lives.

• The PIC will ensure that there will be a stronger focus on quarterly evaluations and the development of more integrative and social goals.

• The PIC has developed a new evaluation sheet for documentation of quarterly reviews of all PCP goals and behavioural support plans where relevant.

• The PIC will commence the development of resident's personal plans in an accessible format.

**Proposed Timescale:** 08/04/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The design and layout of house 4 does not meet the assessed needs of the residents who live in it.

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

**Please state the actions you have taken or are planning to take:**
• The Registered Provider has amended the Statement of Purpose and Function to state that House 4 is home for two residents.
• The Registered Provider will internally reconfigure house 4 to meet the needs of the residents. This will be completed in consultation with HSE maintenance officer and estate project manager to review the design of House 4 to meet the needs of the residents.
• Capital funding will be sought for the new building works in the 2016 capital allocation.
• The Registered Provider will progress a review of the layout of House 4 to identify any changes in structure to ensure best use of rooms available to make sure it can best meet the needs of the two residents who live there.
• The PIC will work with maintenance, residents and staff to ensure the least disruption to the resident's as possible during refurbishment works.

**Proposed Timescale:** 01/04/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The two smoking shelters were in a poor standard of repair.

The covering on a couch in one unit was worn in places.

**14. Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
• The HSE has approved the necessary repair work on the smoking shelters.
• The Registered Provider will ensure that any furniture that is not in a good state of repair will be replaced.

**Proposed Timescale:** 05/02/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The twin bedroom rooms in houses 2 and 3 were not of suitable size to meet the residents' needs.

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

**Please state the actions you have taken or are planning to take:**
• The Registered provider following inspection approved the purchase of screens for the two shared bedrooms to facilitate privacy for the two persons sharing.

• The Registered Provider to meet the long term needs of 4 residents the HSE is at preliminary design stage for a house in the community to meet 4 residents' needs. Following the successful development of such a house each resident in Hawthorns will have their own room.

**Proposed Timescale:** 15/12/2016

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Areas of risk identified during the inspection had not been risk assessed and controls put in place, for example, residents smoking and an oxygen cylinder.

**16. Action Required:**
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
• The Registered Provider has organised for an Oxygen sign for placement outside the house that will be easily identifiable to any services/ persons entering the premises.

• The Registered Provider has ensured that risk assessments have been put in place in relation to Oxygen and smoking since the Inspection. These risk assessments guide practice in relation to smoking control measures for staff.

• The Registered Provider will ensure that individual risk assessments information will be filed in resident's care plans.

**Proposed Timescale:** 27/11/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management of adverse events requires improvement, for example, there was no evidence of improvement and learning from medication errors occurring in the centre.

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

**Please state the actions you have taken or are planning to take:**
• The Registered provider will ensure that nurses who have repeated medication errors will not administer medication until they have undergone a process of performance management including retraining and supervision until deemed competent to administer medication.

• The PIC will work with nursing staff, pharmacists and medical personnel to progress, identify and audit the system in place to ensure all staff learning is improved thereby ensuring medication errors are reduced.

• The Registered provider will ensure that ongoing medication management training is provided for nurses.

• The Person in Charge will continue to do reflective practice exercise with nurses who have medication errors as outlined in the medication management policy in order that nurses will learn from their errors.

**Proposed Timescale:** 12/02/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff in one house were not fully clear about fire evacuation procedures.

**18. Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
• The Registered Provider has ensured that fire evacuation procedures are discussed at weekly staff meetings to ensure that all staff are aware of their duty of care in this regard.

• The Registered Provider will continue to maintain up to date staff training records to ensure that all staff continue to keep up to date with their fire training and participate as part of the monthly fire drill evacuation teams.

• The PIC has completed a process of review and updating all the PEEP information for the residents.

• The PIC assesses staff knowledge of fire safety, evacuation and knowledge of individual PEEPS for residents in their house.

• The PIC has ensured that induction for agency staff includes guidance on the fire procedures and evacuation plan for the designated centre.

**Proposed Timescale:** 19/11/2015

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff could not clarify if one unwell resident had been provided with appropriate care in accordance with their identified needs.

Evidence-based tools used to assess the health-care needs of residents were not utilised in the centre.

**19. 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:**
• The Registered Provider will ensure that relevant evidence based tools are utilised to assess the health care needs of residents i.e. MUST, DISTAT etc..

• The Registered Provider will ensure that that a manual handling assessment is completed for the resident identified who required assistance in mobilising with a hoist.

• The Registered Provider will ensure that that there are specific guidelines on the level of support required during the day and in the evening.
• The Registered Provider will ensure that staff are provided in training in the use of a hoist.
• The Registered Provider will ensure that healthcare plans are consistently developed

for all residents identified needs in the areas of falls, epilepsy and mental health.
• The Registered Provider will ensure that health care plan will be reviewed to ensure that they consistently guide practice.

• The Registered Provider has ensured that all staff have been informed of their professional responsibilities in relation to knowing and taking care of the health needs of residents.

• The PIC will ensure that all staff are appraised of changes/updated on the health status and needs of residents when receiving handover.

• The DON, PIC and CNM3 when doing rounds ensure that staff are conversant and knowledgeable of the health status and needs of the residents.

• The Registered Provider will ensure that the nursing notes are contemporaneous and that any omission of relevant clinical information is addressed immediately.

• The Registered Provider has arranged for annual audits of the person centred plans in the designated centre.

**Proposed Timescale:** 29/01/2016

**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents were not administered medications in the dose prescribed during the inspection.

**20. 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 Person in Charge will ensure that nurses who have repeated medication errors will not administer medication until they have undergone a process of performance management including retraining and supervision until deemed competent to administer medication.

• The PIC has commenced bi monthly audits will take place across the houses to ensure all nurses comply with the Centre's Medication Management Policy and Bord Altranais (NMBI) guidelines.

• The Person in Charge will continue too meet with the pharmacist and review

practices. This meeting will be minuted.

• The PIC has and will continue to discuss medication errors at staff meetings and identify the need to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

• Audit and review with nurses will continue to highlight and address areas such as; the ordering, receipt, prescribing, storing, disposal and administration of medicines.

• Nurses have been advised by the PIC that out of date medicines that are no longer required or in use are stored in a secure manner that segregates them from other medicinal products. A list of all products to be returned are recorded, signed for and returned to the Pharmacy at the earliest possible opportunity.

• The Registered Provider will continue to provide medication management training for nurses to ensure safe systems of medication administration.

**Proposed Timescale:** 01/03/2016

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medications were not securely stored as they could be accessed by all staff.

**21. 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:**
• The Person in Charge will ensure that all medications are stored in accordance with guidelines of the Nursing Board of Ireland and the policy of the designated centre.
• The Person in Charge will ensure that the key to the medication press is held by a registered nurse.
• The PIC will conduct audits quarterly in relation to adherence to medication management policy on the ordering, storage and disposal in the designated centre.

**Proposed Timescale:** 19/11/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Out-of-date medications for disposal or return to the pharmacy were not stored in a manner that segregates them from other medications.

**22. Action Required:**
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

**Please state the actions you have taken or are planning to take:**
• The PIC will assess nurse's knowledge with regard to the disposal of all unused/ out of date medications/ lotions/ creams to ensure that they are segregated from other medications until returned to the pharmacy.

• The PIC will disseminate the HIQA guidance document on medication management to all nursing staff.

• The PIC will conduct audits quarterly in relation to adherence to medication management policy on the ordering, storage and disposal of medication in the designated centre.

**Proposed Timescale:** 27/02/2016

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents were not encouraged to take responsibility for his or her own medications in the centre.

**23. Action Required:**
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

**Please state the actions you have taken or are planning to take:**
• The PIC will ensure that residents who are identified as having capacity to self administer medication will be assessed using the medication management assessment that is available as part of the services medication management policy.

• The PIC will ensure that person centred plans reflect assessment and a skills building goal to support residents to self- medicate.

• The PIC will liaise with the Pharmacist to offer support and information to residents who wish to self –medicate, this education process will also be recorded in the person centred plan.

**Proposed Timescale:** 05/05/2016

**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 confirmation of planning compliance and fees required for the registration of the centre remains outstanding.

**24. Action Required:**
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
• The Registered Provider will ensure that the confirmation details in relation to planning for the designated centre and appropriate fees are forwarded to the Authority.

**Proposed Timescale:** 31/12/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There is an annual review of the quality and safety of care in the designated centre but there was no evidence of learning from the review as action plans to address deficiencies were not clear, concise or measurable

**25. 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 Registered Provider will ensure that an action plan is developed following the annual review of quality and safety of the designated centre.

• The Registered Provider will ensure that actions are specific, measurable and outcome based.

• The Registered Provider will ensure that action plans are reviewed as part of the monthly governance meetings in the designated centre.

**Proposed Timescale:** 15/03/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The systems in place for reviewing the quality and safety of care provided to residents require improvement.

**26. 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:**
• The Registered Provider will use the template for unannounced visits to designated centre as outlined by HIQA "Governance and Management Report"

• The Registered Provider will ensure that an action plan will be put in place for actions identified following the unannounced visit.

• The Registered Provider will ensure that an accessible version of the action plan following the unannounced visits is made available to residents.

**Proposed Timescale:** 15/03/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The role of the person in charge in the centre was not fully clear to all staff.

**27. 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 Registered Provider has ensured since inspection that staff are familiar with the governance and reporting structure of the designated centre both on induction and through the weekly staff meetings.

• The Registered Provider will ensure that at handover the role of the PIC is outlined and that all staff are conversant on the role of the PIC.

• The DON, CNM3 and PIC when doing rounds will assess staff's understanding of the

role of the PIC.

**Proposed Timescale:** 19/11/2015

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Resources were not deployed within the service to ensure adequate staffing at times of the day.

**28. 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 Registered Provider will ensure that the staff resource is regularly reviewed and appropriately allocated to meet individual resident's assessed needs.

• The Registered Provider will ensure that any changes in roster will be communicated to staff with a rationale for same.

• The Registered Provider has reviewed the centre to ensure that the staff resource is adequate for the effective delivery of care and support in accordance with the centre's statement of purpose. The review identified where the redeployment of staff would benefit service delivery and have redeployed staff from night duty thereby increasing the number of staff available to meet gaps that arise in the roster for day duty. This has enabled the residents to participate in additional activities during the day.

• The HSE have sanctioned the recruitment of staff to meet the needs in the centre with interviews taking place this month.

**Proposed Timescale:** 19/11/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The staff roster did not clearly identify the times and location were staff were working.

The roster did not state when agency staff were on duty.

**29. Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
• The Registered Provider has reviewed the centre to ensure that it is adequately resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose.

• The Person in Charge has developed a new roster template which identifies the name, grade, and hours of duty and robustly identifies staff numbers inclusive of agency staff on duty over the 24 hours.

• The DON, CNM3 and PIC when doing rounds ensure that staffing and skill mix is in line with meeting resident's needs.

**Proposed Timescale:** 19/11/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no system of staff supervision in the centre.

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

**Please state the actions you have taken or are planning to take:**
• The Registered Provider has provided Supervision training for the PIC and PPIM's.
• The Registered Provider has updated the Supervision Policy in line with the training.
• The PIC has commenced the roll out of staff supervision in the residential service.
• The Registered Provider will ensure that supervision will be implemented for all staff in the designated centre on a phased basis.

**Proposed Timescale:** 08/07/2016

**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 risk management, complaints and medication management policies were not fully implemented in practice by staff.

**31. 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:**
· The Registered Provider will ensure that all staff are aware of the Centre's complaints, risk management and medication polices, through staff meetings.
· The Registered Provider will ensure that all nursing staff are aware of the Centre's medication polices, through nursing staff meetings.
· The Registered Provider will ensure that there are bi-monthly medication audits to ensure all nurses comply with the Centre's Medication Management Policy.
· The Registered has revised the Centre's Complaints Policy and procedure and the PIC will inform staff of the new complaint procedures at staff meetings.
· The Registered Provider will ensure that there are bi-monthly complaints procedure reviews to ensure all staff comply with the Centre's complaint Policy.
· The Registered Provider will ensure that all staff are aware of the Centre's risk management polices. The PIC will inform staff of the risk management policy at staff meetings.
· The Registered Provider will ensure that risk management are reviewed in the 6 monthly care plan review to ensure all staff comply with the Centre's Risk Management Policy.
· The DON, CNM3 and PIC will check when on walk about individual's understanding of how to implement the policies.

**Proposed Timescale:** 11/03/2016

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents' records were not easily accessible due to the large volume of information contained within their files.

**32. 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:**
• The Registered Provider has in consultation with the PIC developed a file contents index which identifies the appropriate information to be maintained in accordance with the regulations.

• The PIC will carry out the review and audit of current care plans six monthly to ensure they contain and provide only the most up to date information for each resident in order of priority over a twelve month period.

• The PIC will develop an action plan to ensure archiving of residents files/records is carried out at a minimum annually.

**Proposed Timescale:** 12/02/2016

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were gaps in the nursing records to be maintained for residents.

**33. 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:**
• The PIC will ensure that all nurse key-workers are aware of their responsibility to be familiar with the health and social care needs of their residents.

• The PIC will ensure that any changes in resident's health and social status is communicated at handover meetings and also in written records and person centred care plans.

• The Registered Provider will ensure that the nursing notes are contemporaneous and that any omission of relevant clinical information is addressed immediately.

• The PIC will carry out the review and audit of resident's clinical file to assess file information and documentation.

• The PIC will through the process of performance management address deficits in expected nursing practice.

**Proposed Timescale:** 08/04/2016