Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004646
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Angela O'Neill
Lead inspector:	John Greaney
Support inspector(s):	Breeda Desmond; Maria Scally
Type of inspection	Announced
Number of residents on the date of inspection:	18
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:
27 July 2015 09:00	27 July 2015 18:00
28 July 2015 09:00	28 July 2015 19:30

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

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

Summary of findings from this inspection

On 6th November 2015, HIQA took the unprecedented step of applying to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities. The centres were St Raphael's Residential Centre, Oakvale and Youghal Community Hostels, all located on the grounds of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

This report relates to Youghal Community Hostels and is one of the nine inspections of these centres during 2015 which identified serious concerns in relation to safety of residents and poor quality of life for residents. As a result of poor governance and

oversight of the centres, management had failed to identify these issues for themselves, failed to address them effectively and failed to ensure a safe and good quality service for residents.

Overall inspectors identified that a number of significant improvements were required, most notably in the area of governance and management. The previous inspection found that governance and management arrangements were inadequate. This situation remained unchanged. Governance and management arrangements were based on historic practices whereby day-to-day management of all HSE disability services in this region was the responsibility of an acting director of nursing (A/DON) who worked five days each week. The ADON was responsible for four designated centres for adults with disabilities, a number of supported living units and day/activation services. The level of non compliance indicated that the ADON did not have the capacity to manage all of these centres effectively. The other management arrangements in the centre were unclear and did not provide a sufficient level of accountability.

Based on the profile of residents living in the centre, the layout of both premises were not fit for their intended purpose. A number of the residents were advanced in age, however, all bedrooms in community hostel 2 were located upstairs and four of the five bedrooms in community hostel 1 were upstairs. Neither hostel had a stair lift or lift to access the first floor.

Additional required improvements, included:
- staff training
- privacy and dignity
- complaints management
- contracts of care
- support for residents to achieve person goals
- risk management
- fire safety
- staff training
- medication management
- statement of purpose
- records management

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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:
Inspectors found that the provider had not fully addressed the action plan from the previous inspection and additional improvements were required on this inspection to ensure that each resident's privacy, dignity and rights were fully supported. Aspects of the physical environment did not support some residents' privacy and dignity. Inspectors noted that although curtains had been put up by the provider between the beds in shared rooms, these curtains were found to be translucent and so did not ensure each resident's individual right to privacy and dignity. In addition, some curtains did not completely surround bed spaces; consequently residents' privacy could not be facilitated.

Inspectors received completed questionnaires from residents and spoke with residents during the inspection and were told that many residents did not wish to share their bedroom with another resident. However, there was no evidence that this issue was addressed to the satisfaction of the residents .

Inspectors reviewed the complaints management policy and found that the required improvements identified previously by inspectors had not been adequately addressed. The policy did not comply with all the requirements of the Regulations, as an independent nominated person had still not been identified to oversee that all complaints were appropriately responded to and that adequate records were maintained. Inspectors viewed a sample of complaints and found that the action taken as a result of the complaint was not always recorded. Also, whether or not the complainant was satisfied with the outcome was not recorded as required by Regulations.

There was a charter of residents' rights displayed in the units. However, residents reported in questionnaires received by the inspectors that they were not aware of their rights. There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests and capacities.

Residents were consulted about how the centre was planned and run through residents' meetings, the first of which was held in June 2015. Meetings were held with residents on a weekly basis. There was a standing agenda for these meetings, which included issues such as the weekly menu, fire safety, the complaints procedures, social outings and future placements. Inspectors viewed the minutes of these meetings in both units and found that although residents made suggestions regarding the menus or social outings, there was no evidence of action taken as a result of these suggestions and whether or not resident's wishes were facilitated.

Residents had access to independent advocacy services and inspectors noted there was a poster on the notice board in the units with a picture and contact details of an advocate available for residents. Inspectors were informed by staff that an advocacy service also met with residents as a group on a monthly basis in a centre close by, however, the minutes of these meetings were held by the advocacy group and were not available in the centre on the days of the inspection.

Residents' religious rights were supported. Inspectors noted that religious beliefs were respected and measures were in place to accommodate practicing these beliefs. For example, mass was celebrated weekly and residents were able to attend mass in a church nearby.

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:
There was an up-to-date policy on communication. Inspectors observed members of staff interacting with residents and it was evident that they were familiar with each resident's communication needs. Based on a sample of personal plans reviewed, the individual communication requirements were identified and from reading the plans it

was possible identify the communication requirements of individual residents.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
There was evidence that, where relevant, residents were supported to maintain links with family members. There were records of letters sent to family members inviting them to participate in the development and review of personal plans.

There was policy in place about visitors and there were no restrictions on visitors. There were adequate facilities for residents to receive visitors in private.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The inspectors viewed the admissions policy which outlined that admissions were managed in a fair and transparent manner. The admission policy included the procedures for transfers, discharges and the temporary absence of residents; however, it required updating to take account of the need to protect residents from abuse from their peers as required by the Regulations.

While inspectors were shown a draft contract of care, which had recently been sent out to residents and their representatives, at the time of inspection this agreement was not in place.

Judgment:
Non Compliant - Major

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:
Residents' records contained templates to be completed by staff to record residents' assessed needs. These included a one-page profile of the resident providing a brief overview of what the resident considered important such as likes/dislikes, how to best support the resident, and daily/weekly routines. More detailed information was documented in other templates such as communication profile, quality of life, personal health file, behavioural strategies, person centred plan, end-of-life preferences, health action plan, and risk assessments.

Some of the personal plans were comprehensive in relation to identifying goals, timelines for achieving the goals and who had responsibility for supporting the resident to achieve the goals. However, there were significant gaps in other plans. For example, staff informed inspectors about the goals of a resident and about efforts to achieve those goals, but this was not included in the resident's personal plan, and many parts of the plan were left blank. This was also a finding on the previous inspection in April 2015.

There was evidence that some residents were involved in developing their plans but this was not the case for all residents. Based on the sample of plans reviewed they were made available to residents in an accessible format.

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

Findings:
Community hostel 1 was located within a large HSE campus and community hostel 2 was located approximately one kilometre away from the main campus. Both were very old buildings and did not meet the individual needs of residents, cognisant of their ageing profile.

Both community hostels were two-storey buildings. In community hostel 1, residents' accommodation comprised two single bedrooms and three twin bedrooms, all with wash-hand basins; one twin bedroom was located on the ground floor and the remainder were on the first floor with only stairs access to these bedrooms. Residents had personalised their bed area with photographs, mementos and furnishings of their choice. The large sunroom was a relatively recent addition to the premises and it was pleasantly decorated and had comfortable seating; there were separate dining facilities alongside the main entrance. There was another large room with comfortable seating which also accommodated the nurse's station. The kitchen was located off the dining room, however, there was a ramp access down to the kitchen which had not been risk assessed for residents. There was a small storage area located in the hallway which held a commode and wheelchair; there was a voile curtain screening off this area. There was a shower/wet area with assisted toilet and hand wash facilities down stairs. Upstairs there was a bathroom with toilet, wash-hand basin and shower.

The exit from the kitchen led to an enclosed backyard; the shed here housed the laundry facilities and one resident did their own laundry. On the previous inspection, the backyard contained a lot of rubble and rubbish, this area was now free from debris and was safer for residents.

The last inspection report identified that the road surface of the walkway from community hostel 1 to the dining room was quite uneven and unsuitable. While it was reported to inspectors that a report was submitted to HSE Estates for funding, the surface remained unsafe for residents, especially those with reduced mobility or those requiring assistive equipment to mobilise.

Community hostel 2 was located within a walled property. Ten people resided here and their accommodation comprised five twin bedrooms, four with wash-hand basins. However, all bedrooms were located upstairs with stairs access only and inspectors observed that a number of residents had reduced mobility and an unsteady gait. Inspectors observed this resident descending the stairs with the assistance of a member of staff. Residents had personalised their bed area with photographs, mementos and furnishings of their choice. Placement of wall-mounted televisions in three of the five twin bedrooms was totally unsuitable, for example, the television was placed behind the headboard of one resident's bed. Sanitary facilities located upstairs comprised a toilet with wash-hand basin, one shower and toilet that remained out-of-order since the previous inspection in March 2015; there was one functioning bathroom with a shower, assisted toilet and wash-hand basin. There was a toilet with wash-hand basin located near the communal area downstairs. Communal space comprised a large sitting room with comfortable seating, television and music centre. The dining room had tea and coffee making facilities and dining tables were pleasantly decorated. The kitchen was a large room with comfortable seating and flat screen television. Residents had access to the kitchen, scullery and utility room. The smoking area was a porch located to the rear of the building. The previous inspection highlighted that the steps leading from this area to the back garden were narrow and steep and egress for some residents would be difficult cognisant of their reduced mobility, however, this had not been remedied.

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

Findings:
There was a safety statement and health and safety and risk management policy in place which included hazard identification, assessment of risks with measures and actions to be taken. An emergency plan was also available which included the location for the short-term placement of residents should the need arise, however, the medium/long term alternative location was not identified. In addition, the emergency plan identified the 'shut-off' valves for gas, electricity and water in community hostel 1 as if it was part of the campus configuration, however, the safety precautions for community hostel 2 were not detailed. There was a national HSE 'safety incident management policy' that replaced several of the HSE risk and incident management policies which outlined that 'the development and implementation' of this policy 'is supported by local processes', however, an addendum to support local processes was

not evidenced.

The previous inspection highlighted that window restrictors were not in place in upstairs windows in community hostel 1, these were put in place during this inspection to ensure the safety of residents. Previously, there was unrestricted access to cleaning chemicals and protective equipment such as disposable gloves and aprons and this was now remedied whereby all such equipment was maintained in the staff office. The previous report identified that residents did not have appropriate risk assessments relating to their capacity to mobilise unsupervised outside the campus. This was remedied whereby each resident's support plan documentation demonstrated the degree of assistance and/or supervision necessary to safeguard residents.

Incidents and accidents were recorded and this data was analysed to identify trends to enable measures to mitigate risk or potential risk.

There were hand-washing facilities available for staff and advisory signage for best practice hand hygiene was displayed. There were a number of hand hygiene foam dispensers available; the inspectors observed that many opportunities for hand hygiene were taken in accordance with best practice guidelines.

The smoking area was located in the porch and there was fire safety equipment available. A risk assessment was completed for residents who smoked however, the risk management plan examined by the inspectors was not adequate to ensure the safety of the residents in relation to the management of smoking. For example, the smoking management plan for one resident indicated that the resident could light the cigarette within the centre and then proceed to the smoking area.

While the emergency exits were identified in community hostel 2, they were not identified in community hostel 1. There was a brief outline of individual resident's assessment regarding fire safety precautions, however, an evidence-based risk assessment for personal emergency egress was not available for each resident to ensure their safe and appropriate evacuation, should the need arise.

Inspectors viewed the fire equipment service records and found that the fire fighting equipment had last been serviced in September 2014 in both hostels. However, the service record displayed on one fire extinguisher in community hostel 2 was 2012. Although service records indicated that the fire alarm and emergency lighting was last serviced in July 2015 in both hostels, one emergency light in community hostel 1 appeared not to be working on the days of inspection.

The previous inspection identified that while there were floor plans displayed in each hostel identifying where emergency fire safety equipment were located however, they were not adequate as there was no point of reference (for example the front door) to assist residents and visitors; this was not remedied. The emergency floor plan in community hostel 1 displayed the assembly points on campus, however, a centre-specific floor display for emergency purposes was not evidenced for community hostel 1.

Judgment:

Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
There was an up-to-date policy in place on safeguarding vulnerable persons at risk of abuse. Inspectors observed staff members interacting with residents in a respectful manner, however, not all members of staff had received up-to-date training in recognising and responding to abuse. Additionally, not all staff members spoken with by inspectors demonstrated an adequate knowledge of what to do in the event of suspicions or allegations of abuse. In addition, the complaints log contained an allegation of peer-on-peer abuse. Recording allegations of abuse in the complaints log was not in compliance with the complaints policy or the policy on responding to allegations of abuse. This also raised the risk that allegations of abuse would not be investigated correctly and that residents were not adequately safeguarded.

Investigations into allegations of abuse made prior to the previous inspection in March 2015 were ongoing. These allegations related to an allegation of financial abuse and unexplained bruising on a resident. The provider nominee was requested to submit the outcome of these investigations to the Chief Inspector. An additional allegation of abuse had been made subsequent to the inspection in April 2015 relating to unexplained bruising of a resident. This investigation was also ongoing.

A review of a sample of residents' financial records and transactions demonstrated that there were adequate procedures in place to safeguard residents' finances.

There was a multi-disciplinary review of residents requiring behavioural support plans which included the psychiatrist, psychologist and clinical nurse specialist. Based on a review of a sample of behavioural support plans by inspectors there were adequate records of triggers for behaviour that challenges and the manner in which this behaviour presented. However, proactive strategies were not based on the individual needs of the resident. For example, the proactive strategy for one resident was to use low arousal techniques but the plan did not identify the specific low arousal techniques that were effective for this particular resident. Training records indicated that not all members of

staff had received up-to-date training in positive behaviour support.

Judgment:
Non Compliant - Major

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 viewed the incident/accident forms in both units to confirm all notifiable events had been sent to the Chief Inspector as required by Regulations. However, it was noted by inspectors that a resident had gone missing for a short period from one unit in May 2015 and this incident had not been notified to the Chief Inspector as required.

The Chief Inspector had received notification of a change to the person in charge of this centre prior to the inspection; however, on inspection it was noted by inspectors that the information on the notification form did not reflect current management arrangements in the centre. Also, inspectors were informed verbally that the clinical nurse manager 3 (CNM3) who was covering for the person in charge on the second day of inspection was a person participating in management for this centre; however, the Chief Inspector had not received notification of this as required by Regulations.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
There was a policy available in the centre on access to education and training for residents.

The age profile of residents living in the centre was advanced. While there were some residents in their 50s, the majority of residents were in their 60s, 70s and 80s. Records were available of the expressed preferences of residents in relation to participation in activities and many of these were facilitated. Most residents attended activities in the various activation units that were on the grounds of the main campus. Residents that did not wish to attend the activation centres were facilitated to do so.

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

Findings:
Some residents attended their individual general practitioner (GP) in the local town. A medical officer was on-site on an almost daily basis in the campus on which one of the hostels was located and a short distance away from the other hostel. Out-of-hour GP services were also available. Records indicated that residents were reviewed regularly.

A finding of the previous inspection in April 2015 was that comprehensive medical notes of residents attending off-site GP services were not available. This was significant should a resident require out-of-hours GP services, as the visiting GP would not have access to up-to-date medical history of the resident to inform safe and appropriate care. Following that inspection a record of interactions by residents that attended a GP in the local town was created and maintained. The record contained a synopsis of the reason for attending the GP and the treatment prescribed.

Access to multidisciplinary services had improved since the previous inspection. Residents had access to an occupational therapist, a psychiatrist, a psychologist, dental services, nutritional services and speech and language therapy.

Clinical risk assessments to support and inform suitable and safe care were not in place in the sample of personal care plans reviewed, for example, falls risk or pressure area assessment (even though some residents had reduced mobility and were observed to be more dependant).

Meals were prepared in the main kitchen on campus and the main dining room was located alongside the kitchen. Residents had their lunch each day from Monday to Friday in the dining room and a choice of food was available. Breakfast and evening tea was prepared in the kitchen of each of the hostels each day and lunch was prepared here at weekends. Inspectors were informed, and records supported, that residents frequently ate out, in particular at weekends. Residents spoken with by inspectors were complimentary of the food provided. Training records indicated that not all staff members involved in food preparation had received training in food hygiene.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
There was a current centre-specific medication management policy in place, however, it did not detail the procedure for medication recording. A nurses' signature sheet as described in An Bord Altranais agus Cnáimhseachais na hÉireann medication guidelines, was evidenced. Residents' medication was stored securely in a locked trolley within the nurses' station.

The medication administration record was examined and noted that administration of medications was generally recorded appropriately. However, occasionally administration records were not completed by the staff administering the medication; while comments included in the comment section stated medication was administered with the time included, they did not detail the rationale for non-administration of medication at the prescribed time.

Photographic identification was in place as part of residents' prescriptions in line with best practice. There were separate prescriptions sheets for medical preparations and psychiatric medicines. Residents' prescriptions were reviewed regularly by the medical officer, signed and dated and items were discontinued appropriately. Maximum dosages for PRN (as required) medications were documented as well as the rationale for administration of PRN medicines and the residents' response to the medication. Allergy status of residents was recorded as part of their prescription/administration charts in line with best-practice professional guidelines.

Records indicated that medication audits were carried out, however, it was difficult to determine if medication management practice was audited or only the documentation. In addition, the audit from 08/02/14 for psychotropic medication therapy contained a list of residents prescribed such medication, however, there was no evidence of follow-up on the findings, consequently there was no learning or quality improvement possible.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
A written Statement of Purpose was in place. While it outlines some of the items listed in Schedule 1 of the Regulations, the following items required further attention:
1) the specific care needs that the designated centre is intended to meet (for all units)
2) the facilities which are to be provided by the registered provider to meet those care needs (all units)
3) the services which are to be provided by the registered provider to meet those care needs (in all units)
4) the designated centre's policy and procedures (if any) for emergency admissions
5) the number, age range and gender of residents which will be accommodated in the centre (including all units)
6) a description of the rooms in the designated centre including their size and primary function (including all units)
7) the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing complements as required in regulation 14 and 15
8) the organisation structure
9) the arrangements made for dealing with reviews of a resident's individualised personal plan
10) details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision
11) specific arrangements for respecting the privacy and dignity of residents

12) arrangements for residents to engage in social activities, hobbies and leisure interests.

Also the name of the centre outlined in the Statement of Purpose was not in line with the name given to the centre in the registration application form.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose did not adequately outline the management structure or lines of authority and accountability for the designated centre. Inspectors were informed that the person in charge was the acting assistant director of nursing (A/ADON), who was on annual leave on the days of inspection. The A/ADON worked five days each week and was supported by two clinical nurse managers 3 (CNM 3) working on opposite shifts to each other seven days a week.

On the previous inspection the A/ADON was also the person in charge of three other centres. During that inspection the person in charge stated that it was not appropriate for one person to be in charge of four designated centres due to the complexity of the centres involved. She also stated that she did not have the capacity to fulfil this role as required by the Regulations.

On this inspection, inspectors were informed that persons in charge, namely the CNM 3s mentioned above, had been identified for two of the other centres and the A/ADON was now the person in charge of this and one other centre. The Authority had not been notified of this change in management as required by the Regulations.

Inspectors were not satisfied that governance and management arrangements were adequate. Despite the stated management changes, it was evident that operationally, reporting and accountability arrangements had not changed and continued to be based

on historic practices. For example, despite the fact that two new persons in charge had been identified, they both reported to the A/DON who continued to be accountable for all four designated centres and other supported living facilities located throughout the town. Based on discussions with these CNM 3s and the findings of this inspection, inspectors were not satisfied that the person in charge could devote adequate time and energy to the management of this designated centre due to the competing demands of the role of managing other centres.

Consistent with the findings of the previous inspection there was no annual review of the quality and safety of care as required by the regulations. An unannounced visit to the designated centre had been undertaken following the previous inspection.

A process of audit to evaluate the quality of life and the quality of the service provided to residents had commenced. While some audits contained an action plan identifying timelines and responsibility for identified shortcomings, this was not the case for all audits. For example, an audit of incidents in one of the hostels comprised a count of the number of incidents and dates when they occurred but there was no evidence of learning. For those audits that timelines and responsibilities were identified it was not possible to ascertain if the actions were addressed satisfactorily as the timelines set for completion were set at dates future to this inspection.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
There was no period in excess of 28 days when the person in charge was absent and therefore there was no requirement to submit a notification to the Authority.

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:
There were not always adequate resources made available to ensure the facilities and services provided reflected the statement of purpose. Even though, as already stated in Outcome 13, the statement of purpose did not clearly set out the facilities and services to be provided, based on the current profile of residents living in the centre there were not always adequate resources to meet their needs. For example, in hostel 2 there was only one functioning shower and a second shower was out of service since December 2014. In addition to this there were not always enough resources to support residents achieve their individual personal plans.

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:
Inspectors reviewed duty rosters for both community hostels. The staff allocation had increased for community hostel 1 from one staff on night duty to two staff on night duty. Allocation for staff in both community hostels on day duty was two staff. Following review of staffing records, inspectors formed the view that the arrangements to cover the duty roster, sick leave or emergencies was inadequate and there was an over-reliance on staff working prolonged periods of overtime. This was a significant issue cognisant of the complex communication and care needs of residents in the hostels.

There was no personnel file available for some staff in the centre and therefore

inspectors could not determine if all items as listed in Schedule 2 of the Regulations had been obtained for these staff.

Comprehensive records were maintained of staff training, however, these records demonstrated that staff had significant deficiencies in provision of training to enable staff to deliver up-to-date evidenced-based care including protection of vulnerable adults training, moving and handling, fire safety training, medication management training, communication with people with disabilities training and training in behaviours of concern.

Judgment:
Non Compliant - Major

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

Theme:
Use of Information

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

Findings:
The Directory of Residents was reviewed by inspectors who found that it complied with Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, occasionally medication administration records were not completed by the staff administering the medication as also required by Schedule 3 of the Regulations; this is outlined further in Outcome 12.

There was a policy on the provision of information to residents available in the centre along with a residents' guide. However, this guide was not compliant with regulatory requirements as it did not reference the correct centre name, did not contain the terms and conditions relating to residency, how to access inspection reports and the procedure regarding complaints required updating. The residents' guide was available in a format that was accessible for residents.

As referenced throughout this report all of the policies required under Schedule 5 of the

Regulations were made available to the inspectors such as medication management, communication and the provision of behavioural support. However, one of the policies required under Schedule 5 regarding the recruitment, selection and Garda vetting of staff required review as it had not been reviewed since 2007. Also, none of the policies in the centre were found to be centre-specific. The centre also had a policy in relation to visitors but there was no visitor's book available in the centre - this is discussed further under Outcome 3.

As already outlined in this inspection report, a number of documents required further attention. These documents are also outstanding as part of the centre's registration application:
- contract of insurance
- the statement of purpose reflecting the correct centre name
- the resident's guide reflecting the correct centre name
- documents in relation to the persons participating in management
- evidence that the centre complied with planning laws.

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004646
Date of Inspection:	27 July 2015
Date of response:	06 October 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted that although curtains had been put up by the provider between the beds in shared rooms, these were found to be translucent and so did not ensure each resident's individual right to privacy and dignity. In addition, some curtains did not surround bed spaces consequently residents' privacy could not be facilitated.

1. Action Required:

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

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 provision of curtains in the shared rooms will be reviewed in consultation with the residents and lining will be sourced for same as appropriate.
• All residents were consulted regarding screening when this was originally sourced. Not all residents expressed a wish to have screening in place which enclosed their bed. Therefore, the current screening in place reflects the requests of individual residents.
• It is intended that both hostels will be closed as part of a decongregation plan. In securing alternative accommodation it is intended that residents will have single rooms. A request for funding to facilitate closure has been submitted to the HSE nationally. Until funding is secured the HSE locally is not in a position to confirm closure dates.

Proposed Timescale: 31/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors received completed questionnaires from residents and spoke with residents during the inspection and were told that many residents did not wish to share their bedroom with another resident. However, there was no evidence that this issue was addressed to the satisfaction of the residents.

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:
• In line with national policy in relation to decongregation (A Time to Move On from Congregated Settings), a proposal to close these hostels has been submitted to the HSE Nationally. It is anticipated that the hostels could be closed within 6 months of receiving funding.
• Residents in both areas have been consulted in relation to the sharing of room. All, but one, of the residents have expressed that they are content to continue to share rooms.
• Residents in one hostel are aware of the closure plan submitted and know that when this hostel closes they will be facilitated to have single room occupancy.

Proposed Timescale: Until funding is secured the HSE locally is not in a position to confirm closure dates.

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Minutes of residents' meetings in both units indicated that although residents made suggestions regarding the menus or social outings, there was no evidence of action taken as a result of these suggestions and whether or not resident's wishes were facilitated.

3. 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.

Please state the actions you have taken or are planning to take:
• Minutes of the previous meetings will be reviewed at the start of the weekly residents' meeting and will document what action/plans were implemented and indicate any reason as to why an action/plan was not initiated.
• This will provide documented evidence to indicate action/inaction with regards to residents' wishes and preferences.

Proposed Timescale: 05/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests and capacities.

4. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
• Ongoing recruitment will improve staffing in both of these areas. A programme of activities will be developed with the residents to take cognisance of their preferences.
• Each resident will be facilitated to complete a likes / dislikes questionnaire. The information gathered will be used to facilitate their participation in activities that they enjoy and that will meet their needs.

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not comply with all the requirements of the Regulations as an independent nominated person had still not been identified to oversee that all complaints were appropriately responded to and records maintained.

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

Please state the actions you have taken or are planning to take:
• The PIC in each area is the designated complaints officer. Should an independent review of any complaint be required as per "Your Service Your Say" this can be facilitated via the HSE Consumer Affairs department or Director of Nursing once a designated PIC is appointed.
• Complaints will be reviewed in both areas on a weekly basis by the CNM2 and any issues of concerns will be discussed with the PIC.

Proposed Timescale: 01/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors viewed a sample of complaints and found that the action taken as a result of the complaint was not always recorded. Also, whether or not the complainant was satisfied with the outcome was not recorded as required by Regulations.

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 complaints form has been reviewed to ensure that action has been taken in response to all complaints.
• The process of handling a complaint will be reinforced to each staff member and the importance of recording the resident's satisfaction with the outcome and response to the complaint will be highlighted to all staff.
• Complaints will be reviewed in both areas on a weekly basis by the CNM2 and any issues of concerns will be discussed with the PIC.

Proposed Timescale: 01/10/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted that residents did not have a written agreement of the terms on which they shall reside in the centre.

7. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
• A contract of care has been issued to all residents and/or their representatives which is hostel specific.
• An appendix sheet is being developed to provide clear costings that the residents may incur outside of the normal services that are provided.

Proposed Timescale: 16/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admission policy did not take account of the need to protect residents from abuse from their peers as outlined in the Regulations.

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

Please state the actions you have taken or are planning to take:
The admission policy has been updated to reflect the issues identified above.

Proposed Timescale: 21/09/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not being completed properly and there were significant gaps in

some care plans.

9. 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:
1. A review of all residents' care plans is underway.
2. With regards to the individual resident referred to, the care plan is being updated to reflect her wishes.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents were involved in developing their personal plans.

10. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
• PCP meetings are ongoing with the residents and their families. Mitigating factors such as some residents' family members being unable to attend these meetings has delayed this process. Arrangements are being made to facilitate some of these meetings in the family's homes to ensure that all residents and their families are involved in developing their plans.
• It is anticipated that 75% of PCPs will have been reviewed by 31/12/15. As some families have limited availability the remaining PCPs will be facilitated at times and locations that are suitable and will be completed by 31/1/2016.
• Once completed all residents will have had significant input into the development their plans.

Proposed Timescale: 75% by 31/12/15 – 100% by 31/01/2016

Proposed Timescale: 30/01/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Matters to be provided for in premises of designated centres as listed in Schedule 6 were not in place.

11. 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:
• With regards to matters listed in Schedule 6, a closure plan has been submitted with regards to one hostel.
• The requirement to close the other hostel, in line with the "Time to Move on from Congregated Settings" report has also been escalated to the HSE nationally.
Proposed Timescale: The implementation of both of these closure plans is subject to allocation of funding.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The road surface of the walkway from community hostel 1 to the dining room was quite uneven and unsuitable and remained unsafe for residents, especially those with reduced mobility or those requiring assistive equipment to mobilise.

12. 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 roadway to this area has been resurfaced.

Proposed Timescale: 24/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The layout of both premises were not fit for their intended purpose, cognisant of the needs of the residents living there.

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:
A closure plan has been submitted in line with the national guidelines on decongregation.

Until funding is secured the HSE locally is not in a position to confirm closure dates.

Proposed Timescale:

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:
Adequate systems were not in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

14. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
• A comprehensive plan with regards to emergencies and how to respond to same is available in each area.
• The plan will be amended to reflect specific information for each area. In relation to the identified hostel, in the event of the main electricity supply being disrupted a generator will power the area until the main power is restored. No gas is supplied to this area. The generator is serviced annually and records are available from the maintenance department. The oil tank is checked weekly by the maintenance department.
• Each area has an individual risk register. The PIC will meet with the CNM for this centre and other relevant staff on a weekly basis. The agenda for this meeting will include a review of all operational issues, including risks, incidents, complaints or any other significant issues that occurred in the previous week.
• The PIC/ADON will have at least daily face-to-face contact with the CNM in the centre to discuss operational issues including any identified risks, incidents, staffing issues or complaints that have occurred.
• The PICs for all of the designated centres in this area will meet with the Acting DON weekly. (The Acting DON is currently PIC for 2 centres. This will change when a further CNM3 is recruited.) The CMN3 rosters will be reviewed to facilitate this weekly meeting. This group will meet with the CNS on a weekly basis. The agenda for this meeting will also include a review of risks, incidents, safeguarding, staffing and other operational issues that may arise.
• The registered provider will attend these meetings monthly. This meeting will include a review of all red risks, serious reportable events and HIQA notifications.

• Anything highlighted as a red risk will be flagged to senior HSE management.

Proposed Timescale: 09/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a failure to ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

15. 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 centre's safety management system/risk management policy has been in place since January 2015 and provides guidance and directions with regards to all aspects of hazard identification.
• A stand alone hazard identification folder is available in each area and this is reviewed on an annual basis.
• Each area has an individual risk register. The PIC will meet with the CNM for this centre and other relevant staff on a weekly basis. The agenda for this meeting will include a review of all operational issues, including risks, incidents, complaints or any other significant issues that occurred in the previous week.
• The PIC/ADON will have at least daily face-to-face contact with the CNM in the centre to discuss operational issues including any identified risks, incidents, staffing issues or complaints that have occurred.
• The PICs for all of the designated centres in this area will meet with the Acting DON weekly. (The Acting DON is currently PIC for 2 centres. This will change when a further CNM3 is recruited.) The CMN3 rosters will be reviewed to facilitate this weekly meeting. This group will meet with the CNS on a weekly basis. The agenda for this meeting will also include a review of risks, incidents, safeguarding, staffing and other operational issues that may arise.
• The registered provider will attend these meetings monthly. This meeting will include a review of all red risks, serious reportable events and HIQA notifications.
• Anything highlighted as a red risk will be flagged to senior HSE management.

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control the risks identified including risks associated with smoking.

16. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
• Both areas have up-to-date risk assessments with regards to residents that smoke.
• All residents that smoke have individual smoking risk assessments.
• Each hostel has a designated smoking area which has a fire extinguisher/fire blanket and suitable fire proof receptacles.

Proposed Timescale: 21/09/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate means of escape, including emergency lighting were not provided..

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

Please state the actions you have taken or are planning to take:
• Emergency lighting is in place in both areas.
• Both areas have identified fire exit doors
• Fire evacuation drills are carried out in both areas on a 6-monthly basis. The next fire drill is scheduled to take place in November 2015.

Proposed Timescale: 21/09/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not in place for evacuating all persons in the designated centre and bringing them to safe locations, including the provision of suitable personal emergency egress plans and a record of all visitors to the centre.

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

Please state the actions you have taken or are planning to take:
• A visitors' book was previously in place in each centre; however, following consultation with residents this was removed. A new visitors' book will be implemented with immediate effect

• In line with recommendations from the HSE Emergency Response Co-ordinator, in the event of an evacuation residents are brought to another designated centre for a period of up to 4 hours. These designated areas are identified in the emergency evacuation plan and have been deemed as having adequate facilities to cater to the needs of residents.
• In the event that the building is deemed unsuitable to return to after a period 4 hours has elapsed, alternative accommodation will be sourced in consultation with the HSE Emergency Response team.

Proposed Timescale: 21/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not in place for testing fire equipment including all fire extinguishers and emergency lighting.

19. Action Required:
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
• As part of the contract with Atlantic Fire/Horizon Safety Systems, all fire equipment including fire extinguishers/emergency lighting is checked on a quarterly basis.
• Records are available in the centres to reflect same.

Proposed Timescale: 10/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not in place for evacuating all persons in the designated centre and bringing them to safe locations including the provision of suitable emergency evacuation floor plans.

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

Please state the actions you have taken or are planning to take:
• A personal emergency plan will be prepared for each resident.
• Centre-specific floor plans will be available in both centres.

Personal emergency plans to be in place by 30/11/2015
Centre-Specific floor plans to be in place by 12/10/2015

Proposed Timescale: 30/10/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Please state the actions you have taken or are planning to take:
• Engagement has taken place on 26/09/2015 with 2 PMAV instructors to facilitate training in the area of behaviours that challenge with particular emphasis on de-escalation/early intervention.
• The instructors will revert with a series of dates to facilitate this training. It is proposed that all staff in these areas will have undertaken training by the year end.
• In the interim the CNS (Positive Behaviour Support Specialist) will continue to work with staff in all units to facilitate the identification of triggers and techniques for de-escalation.

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

22. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
• Engagement has taken place on 26/09/2015 with 2 PMAV instructors to facilitate training in the area of behaviours that challenge with particular emphasis on de-escalation/early intervention.
• The instructors will revert with a series of dates to facilitate this training. It is proposed that all staff in these areas will have undertaken training by the year end.

• In the interim the CNS (Positive Behaviour Support Specialist) will continue to work with staff in all units to facilitate the identification of triggers and techniques for de-escalation.

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had not received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Please state the actions you have taken or are planning to take:
• A number of training days in relation to the Safeguarding and Protection of Vulnerable adults have been arranged and are ongoing at this time in the centre.
• All staff will have attended this training by the end of 2015.

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate arrangements to protect residents from all forms of abuse.

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

Please state the actions you have taken or are planning to take:
• A number of training days in relation to the Safeguarding and Protection of Vulnerable adults have been arranged and are ongoing at this time in the centre.
• All staff will have attended this training by the end of 2015.
• A weekly review of incident forms has commenced which will enable staff to identify any issues which may arise.
• Safeguarding plans are in place for any residents identified as at risk of abuse

Proposed Timescale: Safeguarding plans and review of incidents: Completed
Training:31/12/2015

Proposed Timescale: 31/12/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident had gone missing from one of the units in the centre in May 2015 and the Chief Inspector had not been notified as required by Regulations.

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

Please state the actions you have taken or are planning to take:
• The notification was submitted retrospectively on the 06/09/2015.
• The resident in question was observed at the end of a shift walking to the nearby garage less than 100 metres from his home. The resident was out of view of staff for approximately 3 minutes. Risk assessments have been updated to reflect same.

Proposed Timescale: 06/09/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Clinical risk assessments to support and inform suitable and safe care were not in place in the sample of personal care plans reviewed, for example, falls risk or pressure area assessment (even though some residents had reduced mobility and were observed to be more dependant).

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

Please state the actions you have taken or are planning to take:
• A falls risk assessment is in place for each resident.
• A Waterlow assessment is also in place for each resident.
• Clinical risk assessments are updated on a yearly basis or more frequently if required.

Proposed Timescale: 10/08/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication administration records were not always completed by the staff administering the medication; while comments included in the comment section stated medication was administered with the time included, they did not detail the rationale for non-administration of medication at the prescribed time.

27. 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 drug kardex has been developed in line with best practice.
• In the event of non-administration of medication it is recorded on the kardex and the rationale for same is documented in the resident's record of care/nursing notes.

Proposed Timescale: 27/07/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose does not contain most of the items outlined in Schedule 1 of the Regulations.

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

Please state the actions you have taken or are planning to take:
The statement of purpose is currently under review and will be updated to reflect the requirements in Schedule 1

Proposed Timescale: 30/11/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

29. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
• Interviews will take place on 06/10/2015 for PIC within this centre. This appointment will ensure that 3 PICs are in place for 4 centres in the area.
• The person appointed will be at CNM3 level.
• Subject to appropriate references, Garda clearance and medical assessment, the recruitment of this person will ensure the issues surrounding the PIC/Governance will be addressed.
• The PIC will be supported by nursing staff, including CNM2, CNM1 and staff nurses; agency specials, care assistants and housekeeping staff. The PIC will receive support and input from the CNS in Positive Behaviour Support. The PIC will report directly to the Director of Nursing for the centre. The DON reports to the Provider Nominee, who in turn reports to the Chief Officer.
• Team meetings are held between all staff members at unit level. The PIC and CNM will have daily face-to-face contact to discuss any operational issues/incidents that have occurred. A weekly unit management meeting is held between the PIC and the CNM2. A weekly Managers' meeting is held with the Director of Nursing and PICs for each of the units in the centre. A Management Governance Group meeting is held monthly which comprises the Provider Nominee, Director of Nursing, Administrator and Persons in Charge for all units in the centre.
• Items discussed at these meetings include, and are not limited to, safeguarding of residents, review of Serious Reportable Events, HIQA notifications, risk management and Quality Improvement.

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Despite the fact that two new persons in charge had been identified, they both reported to the A/DON who continued to be accountable for all four designated centres and other supported living facilities located throughout the town. Based on discussions with these CNM 3s and the findings of this inspection, inspectors were not satisfied that the

person in charge could devote adequate time and energy to the management of this designated centre due to the competing demands of the role of managing other centres.

30. 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:
• Interviews will take place on 06/10/2015 for PIC within this centre. This appointment will ensure that 3 PICs are in place for 4 centres in the area.
• The person appointed will be at CNM3 level.
• Subject to appropriate references, garda clearance and medical assessment, the recruitment of this person will ensure the issues surrounding the PIC/Governance will be addressed.
• The PIC will be supported by nursing staff, including CNM2, CNM1 and staff nurses; agency specials, care assistants and housekeeping staff. The PIC will receive support and input from the CNS in Positive Behaviour Support. The PIC will report directly to the Director of Nursing for the centre. The DON reports to the Provider Nominee, who in turn reports to the Chief Officer.
• Team meetings are held between all staff members at unit level. The PIC and CNM will have daily face-to-face contact to discuss any operational issues/incidents that have occurred. A weekly unit management meeting is held between the PIC and the CNM2. A weekly Managers' meeting is held with the Director of Nursing and PICs for each of the units in the centre. A Management Governance Group meeting is held monthly which comprises the Provider Nominee, Director of Nursing, Administrator and Persons in Charge for all units in the centre.
• Items discussed at these meetings include, and are not limited to, safeguarding of residents, review of Serious Reportable Events, HIQA notifications, risk management and Quality Improvement.

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Consistent with the findings of the previous inspection there was no annual review of the quality and safety of care as required by the regulations.

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

Please state the actions you have taken or are planning to take:
The annual review of quality and safety was undertaken in July / August 2015. This

report was finalised on 17th August.

Proposed Timescale: 17/08/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not always adequate resources made available to ensure the facilities and services provided reflected the statement of purpose.

32. 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:
• Social Care Workers have been recruited to both of these areas. This has significantly increased the number of staff members available.
• The increased staffing levels will ensure the services and the facilities as outlined in the Statement of Purpose are attainable.
• The shower area identified is currently being repaired and refurbished.
• The transfer of an identified resident to an alternative service provider will be progressed as soon as costings have been finalised. A transfer date will need to be agreed with the new service provider. It is anticipated that a move could be facilitated before the end of December.
• As residents transition to alternative accommodation as part of the planned closure there may be increased capacity to facilitate residents' preferences for room locations.

Proposed Timescale: Staffing / Shower -30/11/2015
Alternative placement for identified resident – 31/12/15
Closure plan - Until funding is secured the HSE locally is not in a position to confirm closure dates.

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had personnel files available on site and therefore inspectors could not determine if all items as listed in Schedule 2 of the Regulations had been obtained.

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

Please state the actions you have taken or are planning to take:
• Two staff files which were requested were not on site and will be kept on site in future.
• All staff files will be reviewed to ensure all required information is included.

Proposed Timescale: 12/10/2015
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Following review of staffing records, inspectors formed the view that the arrangements to cover the duty roster, sick leave or emergencies was inadequate and there was an over-reliance on staff working prolonged periods of overtime.

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

Please state the actions you have taken or are planning to take:
• The recruitment of Social Care Workers has increased the staffing in each of these areas and improved the skill mix.
• Three staff members are now rostered to work day-shift and 2 staff members are rostered on night duty with an overlap of 1 staff member up to 10pm at night.
• There is also housekeeping staff on duty 5 days a week

Proposed Timescale: 07/09/2015
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Comprehensive records were maintained of staff training however these records demonstrated that staff had significant deficiencies in their continuous professional development to enable them to deliver up-to-date evidenced-based care.

35. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
• Training matrix is currently being developed.
• Training in both the management of challenging behaviour and communication with residents is currently being scheduled.

Proposed Timescale: 31/12/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One of the Schedule 5 policies required review as it had not been reviewed since 2007.

36. Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
• The Schedule 5 policy referred to is the HSE policy on Garda vetting and recruitment. The 2007 version of this policy is still in use by the HSE nationally. This policy has been agreed between HSE and Garda Siochana.

Proposed Timescale: 27/07/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedure regarding complaints required updating in the resident's guide.

37. Action Required:
Under Regulation 20 (2) (e) you are required to: Ensure that the guide prepared in respect of the designated centre includes the complaints procedure.

Please state the actions you have taken or are planning to take:
• The complaints' process is available in an easy read format and as a standalone document.
• All residents have access to this and it is discussed at the weekly residents' meetings.
• The residents guide makes reference to the complaints' policy; however, this will be reviewed to include more information on the policy, if required.

Proposed Timescale: 31/10/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The residents' guide did not include how to access inspection reports.

38. Action Required:
Under Regulation 20 (2) (d) you are required to: Ensure that the guide prepared in respect of the designated centre includes how to access any inspection reports on the centre.

Please state the actions you have taken or are planning to take:
The residents' guide will be reviewed to state where and how the residents may access the inspection reports.

Proposed Timescale: 31/10/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The residents' guide did not contain the terms and conditions relating to residency.

39. Action Required:
Under Regulation 20 (2) (b) you are required to: Ensure that the guide prepared in respect of the designated centre includes the terms and conditions relating to residency.

Please state the actions you have taken or are planning to take:
The residents' guide will be redeveloped to reflect the requirements of the schedule.

Proposed Timescale: 31/10/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff files viewed by inspectors did not contain all items as required by Schedule 2 of the Regulations and other staff files were not available in the centre.

40. Action Required:
Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:
• Two staff files which were requested were not on site and will be kept on site in

future.
• All staff files will be reviewed to ensure all required information is included.

Proposed Timescale: 12/10/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contract of insurance was not made available to inspectors and had not been submitted as part of the registration application.

41. Action Required:
Under Regulation 22 (1) you are required to: Effect a contract of insurance against injury to residents.

Please state the actions you have taken or are planning to take:
• A copy of the States Claims Agency, HSE State Indemnity for Personal Injury and Third Party Damage was submitted with the registration of another centre. It is a generic document and covers all HSE centres.
• A copy of same was resubmitted on 15/09/2015 to reflect the concern raised.

Proposed Timescale: 15/09/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of insurance was not available to inspectors on inspection and had not been submitted as part of the registration application.

42. Action Required:
Under Regulation 22 (2) you are required to: Insure against other risks in the designated centre, including loss or damage to property and where such insurance is effected advise the residents accordingly.

Please state the actions you have taken or are planning to take:
• A copy of the States Claims Agency, HSE State Indemnity for Personal Injury and Third Party Damage was submitted with the registration of another centre. It is a generic document and covers all HSE centres.
• A copy of same was resubmitted on 15/09/2015 to reflect the concern raised

Proposed Timescale: 15/09/2015