

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Suaimhneas
<b>Centre ID:</b>	OSV-0001749
<b>Centre county:</b>	Sligo
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Teresa Dykes
<b>Lead inspector:</b>	Stevan Orme
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	4
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
24 August 2016 08:50	24 August 2016 20:55
25 August 2016 11:30	25 August 2016 12:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

This unannounced single issue inspection was carried out in response to unsolicited information received by the Health Information and Quality Authority (HIQA). The provider was required by HIQA to complete an internal provider led investigation, which was then followed up by an inspection centred on risk management, safe guarding, residents' social and healthcare needs, complaints procedures and fire safety arrangements at the centre. In addition, as part of the inspection, the inspector reviewed the actions the provider had undertaken in response to actions identified in the previous inspection.

How we gathered our evidence:

As part of the inspection, the inspector met with four residents. Residents were unable to tell the inspector about their views on the quality of the service they received, but the inspector observed residents being supported in a respectful and dignified manner by staff throughout the inspection. The inspector observed residents making choices using their preferred means of communication, and staff were knowledgeable on residents' support needs.

The inspector met with eight staff members and spoke with them about the management and operation of the centre, as well as observing care practices during the inspection. The inspector reviewed documentation such as personal care plans, medical records, risk assessments, medical records, policies and procedures, and staff files. Furthermore the inspector interviewed the person in charge in relation to the needs of residents and the management and operation of the centre.

#### Description of the service:

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided, and was reflective of the centre. The centre was a two storey detached house close to a nearby town, with easy access to all local amenities and shops. The centre comprised of five bedrooms including two with en-suite toilet facilities. The centre had a communal bathroom with bath and shower facilities, as well as two communal sitting rooms, visitors' room, kitchen and dining room. Furthermore, the centre had a utility room with laundry facilities and a sensory activity room. The service is available to adults with disabilities.

#### Overall findings:

Overall, the inspector found that residents were supported by staff to access the local community and work towards their personal goals. The inspector found that the provider had implemented actions identified in the provider lead investigation in relation to the management of challenging behaviour, although this had not led to a significant reduction in the occurrence of incidents; including those between residents. Furthermore, the provider had identified the incompatibility of residents' needs and residents were in the process of moving to services reflective of their needs. In addition, the inspector found that although actions identified in the previous inspection had been addressed, other actions relating to risk and fire management and the premise required further action.

The inspector reviewed ten outcomes on this inspection. The inspector found compliance in three out of the ten outcomes. The inspector found three major non-compliance in relation to safeguarding, risk management, fire safety and the condition of the centre's premise. An improvement plan was requested by the inspector in relation to the centre's premises to be submitted to HIQA within five working days of the inspection. Two outcomes were found to be substantially compliant, and two were found to be moderate non compliance. Other improvements were required in relation to residents' access to the complaints policy, management of residents' personal finances, staff training and governance arrangements at the centre.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

The inspector found residents were supported to engage in activities reflective of their needs, and the centre had a comprehensive complaints policy, although information was not prominently displayed.

The inspector reviewed the centre's complaints policy which detailed the management of complaints and the appeals process. The centre maintained a record of all complaints received, indicating actions taken and outcomes, including complainant satisfaction. There was a user friendly complaints policy, although this was only displayed in the centre's office and therefore not prominently displayed at the centre, and accessible to residents and their representatives.

Staff knowledge was reflective of the complaint policy. Staff told the inspector how they would know whether non-verbal residents were unhappy with any aspect of the centre. Staff told the inspector that residents had access to advocacy services, which was reflected in documentation reviewed.

The centre had a visitor's policy and provided a private visitors' room at the centre. Staff told the inspector that residents' families regularly visited which was reflected in residents' daily care notes and the centre's visitor record.

Residents were supported to engage in activities both at the centre and in the local community which were reflective of their personal interests and needs as identified in their personal plans.

The inspector found that although residents had access to their personal finances as highlighted in the previous inspection, finances remained managed in accounts held by the provider. Furthermore, although all resident financial transactions were recorded and monies were kept in a secure safe, the inspector found that they were not managed in line with the centre's policy in relation to daily auditing requirements.

**Judgment:**

Non Compliant - Moderate

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that residents' social care needs were addressed and were reflective of their assessed needs.

The inspector reviewed a sample of personal plans which were available to residents in an accessible format. At the time of the inspection the inspector found the plans were comprehensive and outlined the health and social care needs of residents. Risk assessments had been completed on aspects including daily living skills and behaviour management showing the support needed by each resident. Risk assessments were regularly reviewed and reflected changes in residents' support needs.

Resident goals were evident in personal plans and included social activities, personal development and transitional planning were residents were moving to a new service. Daily care notes and staff knowledge was reflective of residents' personal plans and identified goals. Personal plans were reviewed annually and more frequently when residents' needs changed. Reviews involved the residents' families and associated multi-disciplinary professionals such as psychologist and behavioural specialists; although the inspector found residents' participation was not evidenced.

The inspector reviewed documentation relating to residents moving to a new service which was reflective of the centre's admission and discharge policy. Transition plans included the involvement of families where residents were not able to fully participate,

and were reflective of staff knowledge of residents' needs.

**Judgment:**

Compliant

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

The inspector found that although the centre's layout was reflective of residents' needs, the centre was not in a good state of repair.

The centre was a two storey detached house and comprised of five bedrooms including two with en-suite toilet facilities. The centre had a communal bathroom with bath and shower facilities, as well as two communal sitting rooms, visitors' room, kitchen and dining room. Furthermore, the centre had a utility room with laundry facilities and a sensory activity room.

Residents' bedrooms were personalised and reflected their needs and interests, although the inspector found the centre's physical condition required maintenance. The inspector found evidence of mould in resident bedrooms, the visitor's room and communal bathroom, which although maintenance records and staff knowledge showed was treated regularly had not been fully addressed. Paintwork to walls throughout the centre were found to be in a poor condition. The inspector found cupboard doors in the kitchen and utility room were damaged or missing.

The inspector found the floor coverings in the kitchen and communal bathroom, as identified in a previous inspection, were marked and damaged. Shower units although not in use, had not been fully removed from residents' bedrooms following the previous inspection.

The external grounds were available to residents. The inspector observed broken flower pots at the front of the house, and the external condition of the centre required maintenance in relation to paintwork, and the garden areas.

Due to the condition of the centre both internally and externally, the inspector requested an improvement plan from the provider within five working days of the inspection on actions to address concerns identified.

**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:**

The centre had health and safety policy and fire management systems in place, although the inspector found these did not address all risks at the centre.

The centre's risk management policy following the previous inspection was centre specific and identified the need to assess risks relating to regulation 26(1)(c).

Risks assessments were in place and were reflective of the centre's safety statement and risk register. Risk assessments were reviewed on a monthly basis, although the inspector found that not all risks observed during the inspection had been identified and assessed. For example the use of a trampoline, and half door leading into the kitchen. Accidents and incidents were recorded and discussed at team meetings. Staff told the inspector how visitors were supported while at the centre, although the inspector found that an incident involving a visitor had not been assessed nor had risk management arrangements been introduced.

There were procedures in place for the prevention, detection and evacuation of the centre in the event of fire, and following the previous inspection fire drills were recorded indicating both residents and staff involvement. Simulated fire evacuation drills were conducted with minimal staff levels, although the inspector found these had not occurred in line with centre's own policy in relation to frequency. Following the previous inspection, weekly fire equipment checks occurred at the centre and records showed that all staff had received fire safety training.

The centre's fire procedure was reflective of staff knowledge, although the inspector found it did not cater for all fire scenarios, with evacuations only being conducted to the rear of the building. Furthermore, the centre's fire procedure was not displayed prominently throughout the centre.



Residents had Personal Emergency Evacuation Plans (PEEPs), although the inspector found these were not reflective of fire drill records examined, which identified additional supports required by a resident during the night in the event of a fire evacuation.

Records were reviewed which showed that all emergency equipment was serviced at appropriate intervals. However, the inspector found that the centre's fire doors were held open by means of manual floor catches, although waking night staff told the inspector that fire doors would be closed at night.

**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:**

The inspector found while there were systems in place to safeguard residents', improvements were required.

There were policies in place for the prevention, detection and response to suspected and alleged abuse, and staff had received training on the protection of vulnerable adults. Staff were knowledgeable when interviewed on what constituted abuse and were also familiar with the centre's arrangements for responding to suspected abuse. Allegations of suspected abuse were recorded and notified to the Health Information and Quality Authority (HIQA) and investigated in accordance with centre's policy.

There had been incidents of peer to peer abuse at the centre, however the provider, on completion of the provider led investigation had put some systems in place to positively manage peer to peer behaviour. For example, incidents of challenging behaviour were recorded and discussed with behaviour specialists on a regular basis and were reflected in team meeting minutes reviewed. Regularly reviewed safeguarding plans were in place following incidents between residents, and reflected in behaviour support plans examined.

The inspector reviewed incident reports on behaviour and found that the provider's actions had not resulted in a significant reduction in incidents between residents. Furthermore, the provider had identified the incompatibility of residents' needs as evident in resident review meetings minutes and resident transitional plans examined as well as staff knowledge. The inspector reviewed evidence of family and advocate consultation in review meetings and transition planning meetings relating to residents moving to more suitable services.

Following the previous inspection findings, the inspector identified areas of improvement. For example, restrictive practices were assessed including the use of external door and window locks. Where restrictive practices were being used they were agreed by the provider's restrictive practice committee and were regularly reviewed by a behavioural specialist. The inspector identified, the use of a half door into the kitchen which had not been assessed as being a restrictive practice. The half door restricted access to the kitchen area as observed during the inspection.

The inspector found good practice in relation to behavioural support. Staff received regular support from a behavioural specialist as reflected in team meeting records and discussions with staff. Staff at the centre received positive behaviour management training, although training records showed that not all staff had received this training.

**Judgment:**  
Non Compliant - Major

### **Outcome 11. Healthcare Needs**

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

**Theme:**  
Health and Development

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

**Findings:**  
The centre supported residents with their healthcare needs in a timely manner, with access to a range of healthcare professionals.

Personal plans and nursing assessments reflected the healthcare needs of residents, and showed access to health professionals such as general practitioner (GP), Ophthalmologists and Psychologists. Documentation showed regular reviews of residents' healthcare needs as and when required, and recommended action was reflected in personal plans and risk assessments.

A review of daily care notes showed actions undertaken by staff were reflective of residents' healthcare needs as identified in their personal plans. Also healthcare records

and discussions with staff showed how staff had supported residents with dignity and respect.

Protocols were in place on the administration of emergency epilepsy medication, clearly showing when medication should be given, including the maximum dosage to be administered.

Although the inspector did not review records of food consumed at the centre, they found that were residents were supported with their dietary needs, personal plans were regularly reviewed with dieticians and speech and language therapists, and were reflective of staff practices and knowledge.

**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):**

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

#### **Findings:**

The inspector did not review all aspects of this outcome as part of the inspection, reviewing only actions taken following the previous inspection.

The previous inspection identified that care assistants had not all received safe administration of medication training. Following the inspection, medication at the centre is now only administered by nursing staff which was reflective of staff knowledge and records reviewed.

**Judgment:**  
Compliant

### **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:**

The inspector found that although the Statement of Purpose was reflective of the practices provided at the centre, it did not fully meet the requirements of the Health Act 2007 Schedule 1.

The inspector found that the Statement of Purpose did not include the correct total staffing complement at the time of inspection. Furthermore, the inspector found the document did not include arrangements for residents to access education, training and employment, and the provider was incorrectly named as the provider representative.

The centre had not provided an accessible version of the Statement of Purpose to residents.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The inspector found that management systems in place at the centre did not fully ensure the service was effectively monitored.

The centre is managed by a full-time person in charge and a Clinical Nurse Manager. Management arrangements were reflective of those described in the centre's Statement of Purpose and staff knowledge.

The person in charge is supported organisationally by a Director of Services and at the centre by a compliment of nurses and healthcare assistants. The person in charge had

systems in place to monitor the effectiveness of service delivery, although the inspector found that they had not identified the following issues.

The inspector found that residents finances were not managed in accordance with the provider's policy in regards to regular daily checks. Furthermore as outlined in Outcome seven, residents' personal emergency evacuation plans were not reflective of identified support needs and fire doors were held open with floor catches. The inspector in addition found that staff had not all received training on fire safety and positive behaviour management.

The person in charge was knowledgeable on the needs of residents and staff, which was reflective of staff knowledge and documents reviewed. For example, minutes of resident personal plan reviews and team meetings. Team meetings occurred regularly at the centre, although the inspector found that opportunities for night staff to attend team meetings were limited. Staff told the inspector that the centre's management was approachable and they were able to raise any concerns about the centre.

The provider conducted unannounced six monthly visits to the centre, in addition to unannounced 'walk rounds' done by the person in charge.

The inspector found that the provider conducted an annual review of care and support at the centre which was reviewed by the inspector. The reviewed report identified both positive practice at the centre and action was identified for areas of improvement.

Following the previous inspection at the centre, formal staff supervision had commenced with all staff. Supervision records reviewed was reflective of discussions with staff.

**Judgment:**

Non Compliant - Moderate

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

The centre's roster was reflective of the needs of residents, although the inspector found that staff had not received training reflective of residents' needs.

The inspector reviewed two staff files and found they included all information required under Schedule 2 of the regulations. Staff knowledge and documents reviewed confirmed that formal supervision had commenced following the action identified in the previous inspection.

Training records showed that as well as access to mandatory training such as fire safety and manual handling, staff also received training specific to residents needs for example positive behaviour management. Although staff knowledge reflected the centre's policies and residents personal plans, the inspector found that not all staff had received training in fire safety and positive behaviour management.

The inspector found that the person in charge and staff were knowledgeable about regulatory requirements including events to be reported to the Health Information and Quality Authority (HIQA) proportionate to their specific roles at the centre.

The centre had both a planned and actual roster in place, although the actual roster was not reflective of the day of inspection. The inspector found the roster did not indicate staff absences on the day. Furthermore, the roster did not show that the clinical nurse manager worked across several designated centres, therefore not reflecting accurately the management arrangements in the centre.

The roster ensured that a nurse and three healthcare assistants were available during the day to meet the needs of residents, as well as a nurse and healthcare assistant at night time, which was reflective of the residents' needs as identified in personal plans, behaviour support plans and risk assessments.

The inspector observed care practices during the inspection and found that residents' needs were addressed in a respectful and timely manner by staff at the centre.

**Judgment:**

Substantially Compliant

## 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:***

Stevan Orme  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Suaimhneas
<b>Centre ID:</b>	OSV-0001749
<b>Date of Inspection:</b>	24 August 2016
<b>Date of response:</b>	14 October 2016

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

Residents personal finances were paid directly into an account held by the registered provider.

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



**1. Action Required:**

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

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

Financial update –We are continuing to operate under the HSE Patient Private property Guidelines with Residents funds being managed within the local Patient Private Property Account (PPP) and the national private property account based in Tullamore.

Financial Manager within Tullamore HSE are satisfied that it is not appropriate to open a post office account or bank account in the name of a service user who cannot give informed consent to this. It follows on from this that the only facility available to manage such service users' monies is a PPP account. This may cause some inconvenience given the geographical spread of community houses but there are no other options available. (1 resident has a post office account opened in his name by Family member – completed.)

Handover document updated to ensure that Financial Balances are countersigned by 2 staff at the beginning & end of their roster day. (Completed)

Resident Financial Competency Assessment template is in Draft form & is being Piloted at present. Same to be finalised when feedback is received from Administration, Residents & Staff. This will be carried out with all residents in the centre to establish their financial competency in relation to managing their own money & what supports are required to maximise independence in this area. 28/10/16 (will be completed)

Proposed Timescale 28/10/16

Person responsible: Person in Charge/ In relation to the PPP accounts this issue is with HSE Tullamore.

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**Proposed Timescale: 28/10/2016**

**Theme:** Individualised Supports and Care

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

The centre's complaints procedure was not prominently displayed.

**2. Action Required:**

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

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

The Complaints Procedure has now being prominently displayed within the Visitors sitting room.

Proposed Timescale: Completed  
Person responsible: Person in Charge

**Proposed Timescale: 07/10/2016**

### **Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

Personal plan reviews did not evidence residents' participation.

#### **3. 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:**

All personal plan reviews for residents within this designated centre will take place within Suaimhneas Community Group Home going forward so all residents will be invited to participate in their individual meetings & reviews according to their will & preferences

House meetings for residents are ongoing within this designated centre & all residents are invited to participate in these meetings with support from their communication partner.

Proposed Timescale: Completed  
Person responsible: Person in Charge

**Proposed Timescale: 07/10/2016**

### **Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

As outlined in the body of the report, the centre was not in a good state of repair both internally and externally.

#### **4. 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:**

Initial Plan submitted to HIQA in relation to works required to be carried out within this designated centre & time frame.

All broken flower pots replaced with new arrangements. (completed

All hedges & trees are trimmed on a seasonal basis.

New Floor Coverings have being requisitioned for Kitchen & Bathroom areas

Cupboard doors in Kitchen area will be replaced .

Quotes being sourced for Internal paint work for community home

Monthly treatment of Mould to commence immediately

Proposed Timescale: 30/11/2016

Person responsible: Person in Charge

**Proposed Timescale: 30/11/2016**

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

**Theme:** Effective Services

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

Risk management systems did not identify and assess all risks at the centre.

**5. Action Required:**

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

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

Risk Assessment for Visitors & Trampoline completed.

Half Door leading to kitchen area has now opened ensuring accessibility for all residents. – completed.

Simulated Fire Drill completed by external Fire Risk Company on 15/9/16 with Residents & Staff to incorporate exit from Front Door. Completed.

Fire Procedures are updated to include the Fire Evacuation through front door. Completed

PEEP form updated for 1 resident in relation to Fire Evacuation & Evacuation Pad in place for this resident. Completed.

Monthly Fire Drills will be conducted on both Day & Night Duty.

Door guards for 2 Doors are requisitioned.

Fire Procedures is displayed prominently within communal areas across this designated centre.

External Contractor have recently being issued & same due back in relation to works required within Suaimhneas Community Group Home. Complete for end Q1 2017

Proposed Timescale: For Fire Works by External contractor - End of 1st Quarter 2017.  
Person responsible: Person in Charge

**Proposed Timescale: 31/03/2017**

**Theme: Effective Services**

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

The centre's fire evacuation procedure was not prominently displayed .

**6. Action Required:**

Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

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

Fire Evacuation Procedure is displayed prominently within communal areas across this designated centre.

Proposed Timescale: Completed.

Person responsible: Person in Charge

**Proposed Timescale: 07/10/2016**

**Theme: Effective Services**

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

The centre fire doors were held open by floor catches.

**7. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

Door guards for 2 Doors are requisitioned. ( 30th Nov 2016 )

External contractor have recently been allocated & same due back in relation to works required within Suaimhneas Community Group Home.

Proposed Timescale: External Contractor - 1st Quarter 2017

Person responsible: Person in Charge

**Proposed Timescale: 31/03/2017**

**Theme: Effective Services**

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

Residents' personal emergency evacuation plans were not reflective of identified needs.

**8. 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:**

PEEP form updated for 1 resident in relation to Fire Evacuation & Evacuation Pad in place for this resident. Completed.

Proposed Timescale: Completed.

Person responsible: Person in Charge

**Proposed Timescale: 07/10/2016**

**Theme: Effective Services**

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

The centre's fire evacuation procedure did not assess all evacuation scenarios.

**9. Action Required:**

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

Simulated Fire Drill completed by Fire Risk Company on 15/9/16 with Residents & Staff to incorporate exit from Front Door. Completed.

Fire Procedures are updated to include the Fire Evacuation through front door. Completed.

Monthly Fire Drills will be conducted on both Day & Night Duty.

Proposed Timescale: Completed.  
Person responsible: Person in Charge

**Proposed Timescale:** 07/10/2016

### **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:**

The inspector found that not all staff had been trained in positive behaviour management.

**10. 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:**

During this inspection 4 staff had not completed the up to date Studio111 Refresher course. 2 of the staff in question have since completed the relevant training in Sept 2016 & the remaining 2 staff are on long term leave. These staff will be prioritised on their return.

Proposed Timescale: Completed.  
Person responsible: Person in Charge

**Proposed Timescale:** 07/10/2016

**Theme:** Safe Services

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

A risk assessment had not been completed on the use of a half door into the centre's kitchen which restricted residents' access to this area.

**11. Action Required:**

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

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

Half Door leading to kitchen area has now opened accessibility for all residents. – completed. Risk Assessment completed on same.

Proposed Timescale: Completed.  
Person responsible: Person in Charge

**Proposed Timescale:** 07/10/2016

**Theme:** Safe Services

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

Residents' needs were incompatible leading to a significant number of challenging behaviour incidents, including between residents.

**12. 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:**

An Annexe is being developed for 1 resident within this designated centre which incorporates a bedroom & large living area with access to all area. This will reduce residents negative interactions in shared communal areas. (28/10/16)

Positive Behavioural support plans are reviewed 6 Monthly or as required.

Transitioning Plans are in progress for all residents within this designated centre. Alternative accommodation identified for each resident—2 residents will remain within the Sligo Services & 2 residents will transition to Leitrim area near their family unit.

Safeguarding screening & safeguarding plans in place as required & reviewed with the safeguarding & protection team in CHO Area 1. (Completed)

Incident Review Group meet on a monthly basis to look at all incidents within this designated centre. Learning from incidents discussed with all staff. ( Monthly)

Proposed Timescale: Quarter 1 - 2017 re-completion of all transition

Person responsible: Person in Charge

**Proposed Timescale:** 31/03/2017

### **Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The Statement of Purpose did not meet all of the requirements of Schedule 1 of the regulations.

**13. 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:**

Statement of Purpose updated containing information set out on Schedule 1.

Proposed Timescale: Completed.

Person responsible: Person in Charge

**Proposed Timescale: 07/10/2016**

**Theme:** Leadership, Governance and Management

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

An accessible version of the Statement of Purpose was not available to residents.

**14. Action Required:**

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

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

An easy read version of the Statement of Purpose will be available to the Residents.

Proposed Timescale: 31 Oct 2016.

Person responsible: Person in Charge

**Proposed Timescale: 31/10/2016**

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

Management systems in place at the centre did not fully ensure the service was effectively monitored.

**15. 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:**

Handover document updated to ensure that Financial Balances are countersigned by 2 staff at the beginning & end of their roster day. (Completed)

Resident Financial Competency Assessment template is in draft form & is being piloted at present. Same to be finalised when feedback is received from Administration, Residents & Staff. This will be carried out with all residents in the centre to establish their financial competency in relation to managing their own money & what supports are required to maximise independence in this area. (Will be completed by 28/10/16 )

Half Door leading to kitchen area has now opened accessibility for all residents. – completed.

PEEP form updated for 1 resident in relation to Fire Evacuation & Evacuation Pad in place for this resident. Completed.

During this inspection 4 staff had not completed the up to date Studio111 Refresher course. 2 of the staff in question have since completed the relevant training in Sept 2016 & the remaining 2 staff are on Long term leave. These staff will be prioritised on their return.

Door guards for 2 Doors are requisitioned.

Fire Training will be completed & updated by staff needing same at our next Training session on 18th October.

Simulated Fire Drill completed by external Fire Risk Company on 15/9/16 with Residents & Staff to incorporate exit from Front Door. Completed.

Actual & Planned Rosters all up to date & identifies the front line staff working in area

Managers roster identifies the 2 areas that she manages & is reflective of the time she is on Duty.

Proposed Timescale: 30th Nov 2016.  
Person responsible: Person in Charge

**Proposed Timescale: 30/11/2016**

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The roster did not reflect staff absences and management arrangements at the centre.

**16. Action Required:**

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

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

Actual & Planned Rosters all up to date & identifies the front line staff working in area. Managers roster identifies the 2 areas that she manages & is reflective of the time she is on Duty.

Proposed Timescale: Completed.

Person responsible: Person in Charge

**Proposed Timescale: 07/10/2016**

**Theme: Responsive Workforce**

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

Staff had not all received training in manual handling.

**17. 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:**

Manual Handling training for all staff will be completed within 2 Months.

Proposed Timescale: Nov 30th 2016.

Person responsible: Person in Charge

**Proposed Timescale: 30/11/2016**