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:	Group H - St Vincent's Residential Services
Centre ID:	OSV-0003931
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Breda Noonan
Lead inspector:	Louisa Power
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	2

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:
25 August 2016 09:00	25 August 2016 18:30
26 August 2016 07:15	26 August 2016 14:30

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

Background to the inspection:
This was an 18 outcome inspection carried out to monitor compliance with the regulations and standards and to inform a registration decision. The previous inspection was on 1 March 2016 and, as part of the current inspection, the inspector reviewed the actions the provider had undertaken since the previous inspection.

How we gather our evidence:
The inspector spent time and interacted with seven residents. The residents did not use verbal communication. The inspector observed that residents were comfortable

in the presence of staff. Staff were very familiar with each resident's individual means of communication. Assistance and support was provided in a dignified and respectful manner. Residents were observed to be offered meaningful choice and their choices were respected.

The inspector also met with two residents' representatives and staff members. The inspector observed practices, joined residents in some of their activities and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspector also reviewed resident and relative questionnaires submitted to the Health Information and Quality Authority (HIQA) post inspection and their feedback is included in the report.

Interviews were carried out with the person in charge and the person nominated to represent the provider.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. The inspector found that the service was being provided as it was described in that document.

The centre was located in a larger building which is only partly occupied by this centre. The rest of this building accommodated other designated centres as well as other facilities such as offices and other staff uses. The centre was located on a campus providing numerous facilities for people with intellectual disabilities in addition to residential accommodation.

The centre was single storey and of masonry construction with a pitched roof. The centre contained single occupancy bedrooms for the residents as well as communal living facilities. The service was available to adults who have severe to profound intellectual disabilities.

Overall findings:
At the previous inspection in March 2016, major non-compliances had been identified in fire safety and the provision of a suitable premises to meet the needs of the residents. The provider reported that actions had not been taken to address these non compliances. The inspector observed that the structure and layout of the centre had not changed since the previous inspection. The centre was not constructed in a manner capable of containing a fire should one occur.

The inspector was satisfied that the person in charge had put systems in place to ensure that many of the regulations were being met. The provider and person in charge did demonstrate adequate knowledgeable and competence during the inspection and the inspector was satisfied that both were fit persons to participate in the management of the centre. This resulted in positive experiences for residents, the details of which are described in the report.

Good practice was identified in the majority of areas examined:
• residents' rights were promoted (outcome 1)
• residents were facilitated to communicate at all times (outcome 2)
• safe medicines management practices (outcome 12).

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

Findings:
Interaction between residents and staff was observed and the inspector noted staff promoted residents' dignity and maximised their independence, while also being respectful when providing assistance. Residents' representatives spoke positively about their care and the consideration provided and reported that nothing is said or done for the resident without the resident's input.

The inspector observed that the involvement of the residents and their representatives was actively promoted in the centre. Minutes of regular monthly house meetings were made available to the inspector. Items discussed included the advocacy, complaints management, new admissions, likes and dislikes, menu choices, social activities and home improvements.

Staff endeavoured to ensure that the residents were consulted about, and participated in, decisions about the support provided and the organisation of the centre. Minutes of the most recent meetings indicated that residents were consulted in relation to purchasing plants for the garden, visits from a local pet farm, purchase of gifts for a peer's birthday and a visit from their pharmacist.

A representative from the centre was supported to attend regular local advocacy meetings attended by peers who lived in designated centres on the campus. Feedback from the local advocacy meetings was brought the advocacy steering committee.

The person in charge confirmed that residents had access to an independent advocate which was facilitated through the National Advocacy Service and information in relation to this service was available for residents. The person in charge outlined that a representative from the National Advocacy Service had arranged to visit the centre and meet residents following the inspection

Residents' ability to choose and control their daily life was actively promoted as far as possible. Daily activities were observed to be led by the residents. Residents were facilitated to rise and retire at a time of their individual choice and directed their daily routine. For example, when a resident refused to participate on a trip to the local shops, her choice was facilitated and alternative activity was provided. Meaningful choices in relation to menu options were observed to be provided.

Interaction between residents and staff was observed throughout the inspection and the inspector noted staff promoted each resident's dignity and maximised independence, while also being respectful when providing assistance. Respectful and positive language was used at all time when talking about and with residents. The inspector observed supported was provided in a dignified and respectful manner.

The resident's capacity to exercise personal independence was promoted. For example, the ability to perform tasks in relation to personal hygiene and dressing was identified through intimate care competency assessments and residents were encouraged to perform these tasks. Personal communications were respected and access to a telephone was provided.

Staff provided support to ensure that residents' maintained their own privacy and dignity. Staff were observed to knock on bedroom doors before entering. Locks were provided on the doors of sanitary facilities. Sanitary facilities were shared and the inspector noted that staff took appropriate measures to promote the privacy and dignity of residents during personal care. Intimate care plans were in place which clearly outlined these measures. The inspector observed that staff respected the centre as the residents' home, rang the front door bell or announced their presence and waited for a response before entering.

There was a complaints policy which was also available in an accessible format and had been reviewed in February 2015. The complaints policy included an independent appeals process as required by legislation. The policy was displayed prominently at the entrance to the centre. Residents' representatives were aware of the policy and the nominated complaints officer. The inspector reviewed the complaints log detailing the investigation, responses and outcome of any complaints. The complaints form also recorded whether the complainant was satisfied. The inspector saw that no complaints were recorded and this was confirmed with the person in charge and staff. The person in charge demonstrated a proactive and positive approach to complaints management.

Residents were encouraged and facilitate to retain control over their own possessions. There was adequate space provided for storage of personal possessions. Records in relation to residents' valuables were maintained and updated regularly in line with the centre-specific policy. Residents were supported to do their own laundry if they wished and adequate facilities were available. A robust system was in place to ensure that

residents' clothes were laundered regularly and returned to the resident.

The person in charge confirmed that residents had easy access to personal monies. Money competency assessments were completed annually for each resident which outlined the supports and training needs, if any, required. The inspector saw that full support was provided to all residents in relation to finances. A transparent and robust system for the management of residents' finances was in place and an itemised record of the all transactions with the accompanying receipts was kept. The itemised record was checked daily and reconciled monthly with bank statements by staff. The person in charge checked the financial records every week and verified the monthly reconciliation for all residents.

Residents are facilitated to exercise their civil, political and religious rights. A blackboard displayed information in relation to rights. An easy read scrapbook in relation to residents' rights had been developed and the inspector observed staff talking residents through the information. Residents were supported to access religious services and supports in line with their wishes.

Judgment:
Compliant

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:
Residents were facilitated to communicate in line with the centre-specific policy, reviewed in July 2015 but documentation was inconsistent. The residents did not use verbal communication or used a limited number of words to communicate.

A comprehensive assessment of each resident's individual communication needs was completed annually and this informed the personal plan developed for this area. In addition, residents had access to specialist input from speech and language therapists, in line with their needs, who completed comprehensive communication assessments. Residents were facilitated to access assistive technology, aids and appliances to promote their full communication capabilities. Communication passports were developed for each resident.

The inspector noted that visual aids and picture books were available to facilitate communication with some residents, in line with the recommendations from the speech

and language therapists. Assistive technologies, aids and appliances such as tablets and laptops were used to facilitate communication with residents.

The inspector observed that staff were very familiar with each resident's individual communication needs. Effective and supportive interventions were provided by staff to maximise residents' communication. A comprehensive list of each resident's individual signs or word bank was in place to guide staff.

The centre was part of the local community. A large screen television was available in the communal area and the inspector observed residents watching current affairs and general interest programmes. Residents also had access to radio, internet and newspapers. Information on local events was discussed at residents' meetings and displayed in the centre.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
Residents were supported to develop and maintain personal relationships and links with the community. Families were encouraged to be involved in the lives of residents.

Positive relationships between residents and family members were supported. Residents were supported to spent time with family including day trips and overnight visits. Regular contact was maintained with family. The inspector spoke with residents' representatives who outlined that family members were made welcome when visiting. There were adequate facilities for each resident to receive visitors and a designated visitors' room was available if residents wished to meet visitors in private.

Staff stated and the inspector saw that families were kept informed of residents' well being on an ongoing basis. Records confirmed that families and residents attended personal planning meetings, birthday parties, Mass in the centre, summer BBQ parties and reviews in accordance with the wishes of the resident.

The inspector reviewed the policy in relation to visitors, which had been reviewed in June 2014. The policy outlined that visitors were 'valued and supported in line with the wishes of individual residents'.

Residents were supported to participate in a range of activities in the local and wider community. An accessible vehicle was available for residents' use. A range of activities were available on the local campus including swimming, art, music, relaxation therapies and attractive walk routes. Some residents were on holidays from their day service at the time of the inspection. On the first day of the inspection, residents went to a folk park and had lunch in a nearby hotel. On the second day of the inspection, residents went to the cinema and for lunch in an adjacent café. Activity planners indicated that residents enjoyed meals out, trips to the hotel spa, walks in local parks and going to sporting events. Residents were supported to use services in the local community such as hairdressers, beauticians, shops and restaurants. Overnight trips away were facilitated and some residents had recently attended a concert with an overnight stay in a hotel incorporated in the trip. The person in charge outlined that residents were going to the seaside for a short break.

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 policy on admissions, transfers and discharge or residents, which had been reviewed in October 2015, was made available to the inspector. The policy outlined the transparent criteria for admission and took account of the need to protect residents from abuse by their peers.

Residents' admissions were seen to be in line with the statement of purpose. The inspector reviewed the records for two residents who had been admitted to the centre recently. A comprehensive assessment of need had been completed for each prospective resident. A multi-disciplinary team meeting was held to discuss the findings in the assessment of need and to identify suitable accommodation for each prospective resident. There was evidence of consultation with the prospective residents and their representatives. Visits to the centre for the prospective residents had taken place on a phased basis and prospective residents had met staff, the person in charge and the residents. The prospective residents had chosen the décor for their bedrooms and had been facilitated to bring personal effects and furniture to decorate their new bedrooms. The residents living in the centre were consulted in relation to the admissions.

A written contract was in place which dealt with the support, care and welfare of the resident in the centre and included details of the services to be provided. The fees and additional charges were included. However, the contracts for the two residents who had recently admitted to the centre were not signed by the resident or their representative on admission.

Judgment:
Substantially Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
A sample of residents' plans was reviewed. An assessment of the health, personal, social care and support needs of the resident was completed annually and the information recorded as part of the assessment was individualised and person centred. The assessment formed the basis of an individual plan of care. A plan of care had been developed for each resident. The plan of care outlined residents' needs in many areas including communication, comprehension and decision making, eating and drinking, mobility, personal care, safe environment, sensory needs, spirituality and relationships. The resident and representatives were consulted with and participated in the development of the plan of care.

Goals and objectives were clearly outlined. There was evidence of resident involvement in agreeing/setting these goals. There was also evidence that individual goals were achieved. The goals outlined would have a positive impact on residents' personal development such as using local services, overnight trips away, attending concerts, participating in a community walk, beauty treatments and moving home. A tracking sheet was used to ensure progress against the achieved goals. The person responsible for supporting the resident in pursuing these goals and the timeframe were clearly identified.

The inspector saw that the plan of care was subject to a review on an annual basis or more frequently if circumstances change. There was evidence to demonstrate that the review was carried out with the maximum participation of the resident and the resident's representatives. The review did assess the effectiveness of the plan and reviewed the goals/aspirations that had been identified. However, the inspector saw that the review of the plan of care was not multidisciplinary for three plans reviewed. The person nominated to represent the provider outlined that a system had been developed to ensure a multidisciplinary review of the plan of care. The system was to be fully implemented by the end of 2016.

Changes in circumstances and new developments were included in the personal plan and amendments were made as appropriate. The inspector saw that personal plans were made available in an accessible format in line with their needs.

A booklet ('hospital passport') was available for staff to record relevant and important information in the event of a resident being transferred to hospital. The hospital passport was completed in advance and contained comprehensive information in relation to the needs of the resident including communication, personal care and healthcare.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
The centre provided many of the facilities required by the Regulations. However, there were aspects of the building which failed to meet the needs of the residents in a satisfactory manner.

The centre was located in a larger building which is only partly occupied by this centre. The rest of this building accommodated other designated centres as well as other facilities such as offices and a main canteen. The centre was located on a campus providing numerous facilities for people with intellectual disabilities in addition to residential accommodation. The building was single storey and of masonry construction

with a pitched roof. Single occupancy bedrooms were provided for the residents as well as communal living facilities.

The building was noted to warm and clean on inspection. There was evidence that efforts to maintain the centre were on-going as part of the centre was noted as having been recently decorated.

There were seven residents living in the centre at the time of the inspection, each of whom were provided with their own bedroom. The bedrooms were noted as being pleasantly decorated and personalised with the resident's possessions. However, it was noted that most of the bedrooms were not provided with any adequate window to provide sufficient natural light, adequate natural ventilation or any adequate view outside for the resident. The windows provided were approximately 400 millimetres in height and were provided along one wall of each of the bedrooms concerned.

However, the bottom of these windows was over 2.6 metres above floor level, which was too high to look out of or to open and close easily. The limited size of the windows also meant that the rooms concerned were not provided with adequate natural light and that there was a dependence on artificial light much of the time within the bedrooms. Conversely, the difficulty posed by the height of the window meant it was not possible to install curtains in a manner that would allow the resident to easily prevent natural light entering the room if desired. These bedrooms were also provided with large glazed panels above the bedroom door facing internally into the corridor, which meant the light level within the room was also dependent on the light level within the corridor, beyond the control of the resident.

One of the bedrooms in use were also noted as being less than seven square metres in gross floor area, which meant that the space within the bedroom was extremely limited, even when the resident's bed was placed along the wall. This was of particular concern for one resident who may require a wheelchair for evacuation and for whom the transfer between their bed and said chair would be made unnecessarily difficult by the limited space available.

Residents were provided with communal living facilities which were noted as being tastefully decorated. There were communal sanitary facilities including an accessible bath or shower. It was noted that assistive equipment such as hoists were in good condition and were serviced when required. However, the inspector noted that a hoist for resident use was stored in the communal living room.

There was a separate kitchen area with suitable and sufficient cooking facilities, kitchen equipment and tableware. Adequate laundry facilities were available. Suitable arrangements were in place for the safe disposal of general and clinical waste.

All parts of the centre were accessible for residents as the circulation routes were adequately sized to ensure residents could easily move around the centre.

A pleasant and accessible garden area was provided for residents and was accessed from the communal living area.

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:
With respect to fire safety, the centre was provided with key fire safety features such as a fire alarm and emergency lighting. There was an adequate number of escape routes which were observed as being clear and available for use on inspection. However, the building was not constructed in a manner capable of protecting the escape routes from the effects of heat and smoke and containing a fire should one occur. There were some fire resistant doors installed within the centre but the provision of same was incomplete. Many of the internal walls would be incapable of containing a fire due to the nature of their construction or due the presence of glazing within the walls.

The centre was provided throughout with a suspended ceiling of lightweight construction with ceiling tiles constructed of particle board or similar material. The ceiling was not capable of containing a fire within the room below should one occur. The roof space above the suspended ceiling was largely continuous as the majority of the internal walls within the centre terminated at the level of the ceiling and did not continue up to meet the roof. This meant that in the event of a fire, heat and smoke would be able to enter the roof space from the room of the fire and travel unchecked throughout the centre bypassing all the walls and doors provided below. There were some smoke barriers installed but the provision was incomplete and the barriers present were not in a condition that would allow them to stop smoke spread effectively due to holes in them. This could potentially lead to occupants being trapped due to the unseen movement of heat and smoke throughout the centre in the roof space before descending in an area of the centre remote from the fire. Smoke detectors linked to the fire alarm were provided within the roof space in order to detect smoke within it at an early stage.

The inspector viewed documentation relating to the fire safety maintenance and evacuation procedures in place within the centre. Fire equipment was serviced annually, most recently in May 2016. The fire hydrant system was serviced annually, most recently in January 2016. The fire panel was serviced quarterly, most recently in July 2016. Emergency lighting was serviced quarterly, most recently in June 2016. Records of daily, weekly and monthly fire checks were to be maintained in line with the centre's fire policy. These checks included inspection of the fire panel, escape routes, fire doors,

emergency lighting and fire equipment. However, the inspector noted a gap on the daily fire checks on 8 July 2016.

There was a fire evacuation procedure in place and was displayed throughout. The needs of the residents in the event of an evacuation had been assessed and recorded by staff in personal evacuation plans (PEEPs). The PEEPs were kept in easily accessible locations adjacent to the fire procedure notices. Staff were aware of the fire evacuation procedures and each resident's individual PEEP.

Records viewed on inspection indicated that there was a regular programme of monthly fire drills in place. Discussions with staff members indicated that fire drills were conducted in line with best practice and included simulated evacuations based on particular scenarios. Drills simulated both day and night time conditions. The inspector noted that a detailed description of the fire drill, duration, participants and any issues identified was maintained for many fire drills. However, for four fire drills since March 2016, the number of residents present at the time of the drill was not recorded. Therefore, it could not be demonstrated that all scenarios of staffing ratios and resident occupancy had been considered to ensure a safe and timely evacuation of all persons in the centre.

There was a health and safety statement in place which outlined general aims and objectives in relation to health and safety within the centre. The health and safety statement was augmented by a risk management policy, last reviewed in March 2015. The risk management policy outlined broad safety statements, the procedures for recording, reporting and investigation of accidents, a range of centre-specific risk assessments, an assessment of each risk and the controls identified as necessary to reduce each risk.

The inspector reviewed the risk register which was attached to the risk management policy and saw that there was a system to identify and review hazards on an ongoing basis. The risks identified specifically in the regulations were included in the risk register. There was evidence that risk assessments had been implemented in practice and were kept under continual review.

A comprehensive health and safety audit had been completed in August 2016 which examined areas including the safety statement, waste disposal, lighting, accessibility, hazard identification, fire safety and risk assessments. This was augmented by weekly health and safety 'walkabouts' within the centre were made available to the centre where areas such as fire safety, electrical appliance, trailing leads, lighting, maintenance, floor covering, ventilation and waste management were examined. Any actions required as a result were seen to be completed in a timely fashion.

A comprehensive emergency plan was in place which covered events such as natural disasters and utility failure. Provision was made to cover an event where the centre may be uninhabitable.

The inspector reviewed a sample of incident forms and saw that accidents and incidents were identified, reported on an incident form and there were arrangements in place for investigating and learning from accidents. The inspector noted that the improvements

identified were implemented in a timely fashion. Incident forms were reviewed by the senior staff in a timely manner.

Procedures were in place to for the prevention and control of infection. A comprehensive infection prevention and control policy was available, dated July 2015. The centre was visibly clean throughout. Hand hygiene facilities were provided in appropriate locations for staff, residents and visitors. Staff prompted residents in relation to hand hygiene. Staff confirmed that personal protective equipment such as gloves and aprons were available. A robust procedure was in place for the safe handling of laundry and alginate bags were available for the safe handling and segregation of soiled laundry. The training matrix indicated that all staff members had completed infection prevention and control training.

Comprehensive manual handling plans were in place developed in consultation with the occupational therapist and the physiotherapist. Staff demonstrated adequate knowledge of the plans and safe moving and handling practices were observed by the inspector. Equipment was serviced regularly, in line with manufacturer's recommendations.

Bed rails were in use in the centre. Risk assessments had been completed and were reviewed regularly. Adequate controls were in place including regular documented checks of the residents whilst bed rails were in use. Regular documented checks were completed weekly to ensure safety and to prevent entrapment due to ill fitting bedrails.

Vehicles for resident use were available and records confirmed that the vehicles were roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

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:
Systems were in place to protect residents from being harmed or suffering abuse. Supports were in place to ensure that residents were provided with emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges.

There was a policy and procedure in place in relation to the safeguarding of vulnerable adults, reviewed in January 2016. The policy identified the designated safeguarding officer and their deputy. The policy and procedure were comprehensive, evidence based and would effectively guide staff in the reporting and investigation of incidents, allegations or suspicions of abuse. The policy included a reporting pathway if the allegation was made against a member of the management team.

The intimate care policy, dated May 2015, outlined how residents and staff were protected. Each resident had an intimate care plan which was reviewed on a regular basis.

Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Staff outlined that there was a 'zero tolerance' approach taken by the organisation in relation to abuse. Residents' representatives outlined that residents were safe in the centre and that they knew who to talk to if they needed to report any concerns of abuse.

The provider and person in charge monitored the systems in place to protect residents and ensure that there are no barriers to staff or residents disclosing abuse. A robust recruitment and selection procedure was implemented, staff stated that there was an open culture of reporting within the organisation and all staff received ongoing training in understanding abuse.

The person in charge confirmed that staff worked alone in the centre at night and robust measures were in place to safeguard residents including unannounced visits from the night supervisor, an open visiting policy and mandatory staff training. The contact details for the designated safeguarding officer and the confidential recipient were easily accessible in the centre. Measures were in place to assist and support residents to develop the knowledge, self-awareness, understanding and skills needed for self care and protection.

The person in charge and person nominated to represent the provider confirmed that there had not been any incidents, allegations and suspicions of abuse since the previous inspection. The person in charge and provider demonstrated comprehensive knowledge in relation to the recording and appropriate investigation of such incidents in line with national guidance and legislation.

A policy was in place to support residents with behaviour that challenges, reviewed in May 2014. The policy was comprehensive and focussed on understanding the function of the behaviour, responding and communicating appropriately and identifying triggers for the behaviour. The training matrix indicated that initial and refresher training in the

management of behaviour that is challenging including de-escalation and intervention techniques was mandatory for all staff. However, the person in charge outlined and the training matrix indicated that one staff member required refresher training in this area.

The inspector reviewed a selection of plans for support behaviour that challenges and spoke with staff. Residents and their representatives were involved in discussions and reviews that had been arranged to support residents to manage their own behaviour. Specialist input had been sought and clear strategies were in place to support residents to manage their own behaviour and staff were able to describe the strategies in use.

The policy in relation to restrictive practices was made available to the inspector. The policy had been reviewed in July 2014, was comprehensive and was in line with evidence-based practice. Staff were knowledgeable in relation to the policy. Where restrictive practices were in use, the use was guided by a centre-specific policy and followed an appropriate assessment. A risk balance tool was used prior to the use of restrictive practices, a clear rationale was documented, multi-disciplinary input was sought and less restrictive alternatives were considered.

Judgment:
Substantially Compliant

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

Theme:
Safe Services

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

Findings:
The inspector noted that a comprehensive record of all incidents was maintained. Notifications to HIQA were made in line with the requirements of the regulations.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
There was a policy in place on access to education, training and development which was made available to the inspector. A number of day services were available to residents in line with their needs. Staff outlined that residents attended a day service on campus for a number of hours each week. A number of activities were provided in the day services including swimming, music, arts and crafts, relaxation, exercise classes, life skills and beauty therapy.

An individualised plan of care in relation to education and training was developed for each resident. The person in charge outlined that each resident's educational, training and employment goals were discussed at the annual review of the resident's personal plan. Staff were aware of these goals and, where appropriate, supported residents in pursuing and achieving these goals.

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:
Residents were supported on an individual basis to achieve and enjoy best possible health. However, there was a delay in relation to accessing allied healthcare professionals following referral.

Residents' healthcare needs were met through access to health care services and appropriate treatment and therapies. A medical practitioner of their choice was available

to each resident and an "out of hours" service was available if required. Access to a medical practitioner was facilitated regularly. There was clear evidence that there treatment was recommended and agreed by residents, this treatment was facilitated. Residents' right to refuse medical treatment was respected.

Where referrals were made to specialist services or consultants, staff supported residents to attend appointments. In line with their needs, residents had ongoing access to allied healthcare professionals including psychiatry, dietetics, speech and language, occupational therapy, physiotherapy, dental and psychology. However, the inspector noted that a referral had been sent to the psychology department for a resident on 29 September 2015. The referral had been accepted by the organisation's psychology department and the resident had been placed on the waiting list. However, at the time of the inspection, the resident's referral was still outstanding despite repeat referrals sent, following multi-disciplinary team input, in April and July 2016.

A sample of residents' healthcare plans was reviewed. Plans of care had been developed in line with residents' individual healthcare needs such as epilepsy, high blood pressure, mobility, oral care, women's health, constipation, continence, mental health, skin care and nutrition. Staff with whom the inspector spoke were knowledgeable in relation to the implementation of the plans of care.

The management of epilepsy was in line with evidence-based practice. Residents were supported to attend regular reviews in relation to epilepsy management. Staff with whom the inspector spoke were conversant in the management of epilepsy and seizures. Where rescue medicine was prescribed, the inspector saw that the medicine was available at all times and staff had been trained in the administration of this medicine. Individualised epilepsy care plans had been developed for all residents with a diagnosis of epilepsy which outlined type of epilepsy, description of seizures, identified triggers, medicines prescribed, frequency of review, 'rescue' medicines prescribed and management of seizures.

The end of life policy was made available to the inspector which described the procedure to be followed in the event of a sudden or unexpected death. The inspector noted that a comprehensive and sensitive discussion had taken place with residents and their representatives to residents' views in relation to end of life. A plan of care for end of life was developed based on this discussion.

Residents were encouraged and enabled to make healthy living choices in relation to exercise, weight control and healthy eating. Residents had access to a speech and language therapist, clinical nurse specialist in nutrition and dietician, in line with their needs. A robust system was in place to ensure that recommendations were implemented. Residents were encouraged to be active through exercise classes, swimming and walking.

Breakfast and snacks were prepared on in the centre's kitchen whilst dinner and the evening meal were prepared in the main kitchen. Food preparation was observed to be a social and inclusive activity. Staff also outlined that residents were encourage to participate in baking. The inspector saw that a meaningful choice was provided to residents for all meals. The meals outlined by staff and residents were nutritious and

varied.

The inspector observed a healthy choice of cereals, cooked eggs, hot/cold beverages, fresh fruit and yoghurt were available for breakfast. On second day of the inspection, dishes available for the evening meal included a cold meat salad or toasted sandwiches. Staff outlined to the inspector that provisions were available to prepare an alternative hot light evening meal if required. Staff on night duty outlined that a snack was provided to residents before retiring and the kitchen was accessible at all times if residents requested refreshments during the night.

The inspector observed meals to be unhurried and dignified. The décor of the dining room was tasteful and homely. Dining tables were attractively and invitingly set. The inspector noted that meals were plated and attractively presented in an appetising manner. Assistance was observed to be provided in a respectful manner.

There were ample supplies and choice of fresh food available for the preparation of meals. Outside of set mealtimes, residents had access to a selection of refreshments and snacks. The inspector saw that residents were regularly offered a choice of hot/cold beverages. There was adequate provision for residents to store food in hygienic conditions. Adequate supplies of suitable alternatives were provided for residents who had a dietary intolerance and staff demonstrated adequate knowledge of suitable food choices.

Residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents' needs was available in an easy read format.

Judgment:
Substantially 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:
Medicines for residents were supplied by a community pharmacy. Staff confirmed that the pharmacist was facilitated to meet her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. The inspector saw a notice informing in relation to an upcoming visit by the pharmacist to the centre and this had been discussed with residents at a recent residents' meeting.

There was a centre-specific medicines management policy and had been reviewed in July 2015. The policy detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines. Staff demonstrated an understanding of medicines management and adherence to guidelines and regulatory requirements. The inspector noted that medicines were stored securely.

A sample of medication prescription and administration records was reviewed. Medication prescription records were current and contained the information required by legislation. Medication administration records identified the medicines on the prescription and allowed space to record comments on withholding or refusing medications.

The person in charge outlined that nursing staff administered medicines. Nursing staff demonstrated good knowledge in relation to medicines management and confirmed that they had completed training in this area. Competency assessments were completed for all nursing staff. The inspector observed the administration of medicines and saw that the practice was in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais. The nurse outlined the indications of the medicines to be administered and medicines were administered in a respectful manner.

The medicines management policy outlined that residents were encouraged to take responsibility for their medicines, in line with their wishes and preferences. A comprehensive and individualised risk assessment had been completed for all residents which took into account cognition, communication, reception and dexterity. At the time of the inspection, the inspector saw and staff confirmed that no resident was taking responsibility for his/her own medicines. Appropriate controls were outlined in the policy to ensure adequate oversight to ensure compliance and concordance.

Staff outlined the manner in which medicines which were out of date or dispensed to a resident but were no longer needed are stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records. A system was in place for reviewing and monitoring safe medicines management practices. The results of the most recent medicines management audits in May 2016 were made available to the inspector. The inspector confirmed that actions had been completed.

When residents left the centre for holidays or days out, a documented record was maintained of the quantity and medicines given to the resident and/or their representative. This record was signed by staff and the resident and/or their representative. A similar record was maintained when the resident returned to the centre and the quantities were reconciled by staff.

The inspector saw that medication related errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. Learning from

incidents was clearly documented and preventative actions were seen to be implemented.

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):
No actions were required from the previous inspection.

Findings:
The statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. The statement of purpose was made available to residents and their representatives.

The statement of purpose contained all of the information required by Schedule 1 of the regulations and the inspector found that the statement of purpose was clearly implemented in practice. The statement of purpose had been reviewed in August 2016.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
There was evidence of a defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. A person was nominated to represent the provider and was the person in charge's line manager. There was evidence of regular contact between the person in charge and her line manager. The person in charge was also appointed as the person in charge in one other centre which was also located on the campus. A clinical nurse manager (CNM) 1 was appointed in the centre to ensure the effective governance, operational management and administration of the centre. The inspector observed a good and supportive working relationship between the person in charge and the CNM 1.

The inspector concluded that the person in charge provided effective governance, operational management and administration of this centre. The person in charge was registered nurse in intellectual disability (RNID) with a number of years' experience working in the sector. The person in charge was undertaking a post graduate qualification in the area of healthcare management at the time of the inspection. The person in charge was employed full time. The person in charge demonstrated an in-depth knowledge of the residents and the residents were very comfortable in her presence.

The provider had arranged for an unannounced visit to the centre in the last six months to assess quality and safety of the care and support in the centre. The most recent unannounced visit which had been completed in August 2016. There was evidence of progress against the action plan.

The annual review of the quality and safety of care in the centre had been completed in November 2015. The review was comprehensive and based on the standards and regulations. Areas for improvement were identified and actions completed in a timely fashion. There was evidence of ongoing quality assurance and improvement through regular audits in areas such as restrictive practices, health and safety, incident management, handovers and mealtimes. The audits identified areas for improvement and audit recommendations. Improvements were brought about as a result of learning from audits.

An annual survey of residents' representatives had been completed in December 2015. The results were made available to the inspector which demonstrated a high level of satisfaction with the service.

A quality improvement register had been put in place by the person in charge which outlined a number of areas including complaints management, consultation with residents, advocacy, social integration, family links, risk assessments, premises, training and activities.

Judgment:
Compliant

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 had been no periods where the person in charge was absent from the centre for 28 days or more since the previous inspection.

A clinical nurse manager was identified to deputise for the person in charge in her absence. The clinical nurse manager demonstrated that she had a good understanding of her responsibilities when deputising for the person in charge. The inspector was satisfied that suitable arrangements were in place for the management of the designated centre in the absence of the person in charge. The provider was aware of the requirement to notify the Chief Inspector of the proposed absence from the designated centre in line with the regulations.

Judgment:
Compliant

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

Theme:
Use of Resources

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

Findings:
The inspector found that centre was adequately resourced to ensure the effective safe and effective delivery of care and support in accordance with the statement of purpose. Sufficient resources were available to support residents to achieve the goals. The inspector observed that there was sufficient transparency in planning and deployment of resources in the centre. The facilities and services available in the designated centre reflected the statement of purpose.

Judgment:
Compliant

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:
There was a planned and actual staff roster in place which showed the staff on duty during the day and at night. Based on observations, a review of the roster and these inspection findings, the inspector was satisfied that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs of the residents. The person in charge outlined that she endeavoured to ensure that a regular team supported residents and provided continuity of care and support. The person in charge described that only agency staff familiar with the centre and the residents were utilised.

There was evidence of effective recruitment and induction procedures; in line with the centre-specific policy, last reviewed in June 2014. Staff files were kept centrally at the organisation's head offices and a sample was examined prior to the inspection. The staff files contained many of the elements required under Schedule 2. However, one staff file did not contain the details and documentary evidence of any relevant qualifications or accredited training.

Staff were observed to be supervised appropriate to their role on a formal and informal basis. Regular staff meetings were held and items discussed included health and safety, fire safety, concern and welfare, residents' needs, audits, infection prevention and control. A formal and meaningful supervision and appraisal system was in place for all staff.

Staff with whom the inspector spoke were able to articulate clearly the management structure and reporting relationships. The inspector saw that copies of both the regulations and the standards had been made available to staff and staff spoken with demonstrated adequate knowledge of these documents.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies the programme reflected the needs of residents. However, the training matrix indicated that two staff

members required refresher training in manual handling.

The inspector saw that confirmation was sought from the agency to ensure that agency staff assigned to the centre had the appropriate training and the required documentation and vetting had been sought.

Records confirmed that volunteers received supervision and were vetted appropriate to their role and level of involvement in the centre.

Judgment:
Substantially Compliant

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):
No actions were required from the previous inspection.

Findings:
The records listed in Schedules 3 and 4 of the regulations were maintained in the centre. The records listed in Schedule were held centrally at the organisation's head office.

All of the key policies as listed in Schedule 5 of the regulations were in place. These policies were stored in the centre and were easily accessible for staff. A process was in place to ensure that policies and procedures were reviewed and updated to reflect best practice and at intervals not exceeding three years.

Records were kept securely, were easily accessible and were kept for the required period of time. A system was in place to store residents' records were stored securely. The inspector found that the system in place for maintaining files and records was very well organised.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the regulations.

Judgment:
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:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Group H - St Vincent's Residential Services
Centre ID:	OSV-0003931
Date of Inspection:	25 August 2016
Date of response:	27 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 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contracts for the two residents who had recently admitted to the centre were not signed by the resident or their representative on admission.

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

1. 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:
The person in charge will provide a copy of the contract to the resident's representative for their information and a copy for signing. The resident will also be supported to sign their contract with the service.

Proposed Timescale: 30/11/2016

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:
Reviews of the personal plan were not multi-disciplinary.

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

Please state the actions you have taken or are planning to take:
The person in charge and key worker for each resident will consult with each multi-disciplinary team member to ensure that resident will have their personal plan reviewed by the relevant multi-disciplinary team members. Going forward each plan will also be reviewed as part of the resident's annual multi-disciplinary team meeting.

Proposed Timescale: 31/12/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The following matters were not adequately provided for with respect to the premises:
• facilities for storage of equipment were not adequate
• bedroom accommodation was not of a suitable size and layout in all cases.

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

Please state the actions you have taken or are planning to take:
The provider nominee will arrange for the Director of Logistics to review the bedrooms and make recommendations for changes to ensure all bedrooms are of a suitable size and layout for the residents.
The provider nominee and Person in Charge will review the centre and involve the Director of Logistics if necessary to ensure that adequate space for storage is provided for the centre. The bedrooms and storage will be reviewed by 30/11/2016 and recommendations from same will be completed by 28/02/2017.

Proposed Timescale: 28/02/2017

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:
Daily fire checks were not completed in accordance with the centre's fire policy.

4. 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:
The person in charge and in her absence the contact person each day will ensure that the daily fire checks are completed and recorded. The person in charge has discussed this with all staff in the centre in the September staff meeting.

Proposed Timescale: 20/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The escape routes were not constructed in a manner capable of being maintained free from heat and smoke in the event of a fire.

5. 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:
The provider nominee will arrange for the Director of Logistics to review the escape routes from the centre and establish what measures can be taken to ensure they provide adequate means of escape in the event of fire, this will be completed by 30/11/2016. The nominee provider will request the necessary funding to complete any recommendations made by the Director of Logistics.

The provider is not satisfied with the current accommodation and is actively planning to find more suitable accommodation for all of the residents. The assessment of need for each resident will determine that most suitable accommodation requirements and the Director of Logistics will engage with Limerick County and look for Capital Assistance Grant to purchase 2 houses in the community during 2017 for the transfer of residents from this centre.

Proposed Timescale: 31/01/2018

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, the building was not constructed in a manner capable of containing a fire should one occur.

6. 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:
The provider is not satisfied with the current accommodation and is actively planning to find more suitable accommodation for all of the residents. The assessment of need for each resident will determine that most suitable accommodation requirements and the Director of Logistics will engage with Limerick County and look for Capital Assistance Grant to purchase 2 houses in the community during 2017 for the transfer of residents from this centre.

Proposed Timescale: 31/01/2018

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
For four fire drills since March 2016, the number of residents present at the time of the drill was not recorded to ensure that there are adequate arrangements for timely evacuation of all residents in the centre.

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

Please state the actions you have taken or are planning to take:
There was a fire drill completed post inspection which detailed the number of residents present and the time to evacuate all residents safely. All fire drills, day and night, will in future detail the number of residents present at the time of fire drill.

The new fire policy when review is completed will also state that the number of residents present will be stated when recording fire drills.

Proposed Timescale: 31/08/2016

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:
One staff member required refresher training in the management of behaviour that is challenging including de-escalation and intervention techniques.

8. 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:
The person in charge has scheduled this staff member for the required refresher training, same was completed on 11/10/2016. The person in charge will ensure that all staff in the centre are scheduled as required for all mandatory training and for refresher training as appropriate.

Proposed Timescale: 11/10/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A referral to psychology since September 2015 remained outstanding.

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

Please state the actions you have taken or are planning to take:
The provider nominee and person in charge have discussed this referral with the head of psychology. A date for psychology to action the referral was agreed and completed on 14/09/2016.

Proposed Timescale: 14/09/2016

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** One staff file did not contain the details and documentary evidence of any relevant qualifications or accredited training. **10. 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:** The provider nominee has discussed this failing with the Director of Human Resources, all files will be reviewed by the human resource office to ensure that all relevant documentation is available in the file, including documentary evidence of relevant qualifications and accredited training.
Proposed Timescale: 30/11/2016
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Two staff members required refresher training in manual handling. **11. 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:** The person in charge has scheduled the two staff members for refresher training, one completed on 18/10/2016 the second due for completion on 08/11/2016. The person in charge will ensure that all staff in the centre are scheduled as required for all mandatory training and for refresher training as appropriate
Proposed Timescale: 08/11/2016