

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
Centre ID:	OSV-0004579
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Provider Nominee:	Una Nagle
Lead inspector:	Julie Hennessy
Support inspector(s):	Louisa Power
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 03 August 2016 08:00 To: 03 August 2016 16:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This monitoring inspection was the third inspection of this centre carried out by the Health Information and Quality Authority (HIQA). The first inspection of this centre took place on 8 March 2016 and the second on 20 April 2016.

The purpose of this inspection was to follow up on progress made since the previous inspection. While progress had been identified between the first and second inspections, four of 10 outcomes remained at the level of major non-compliance at the most recent inspection.

Description of the services

The centre was a two-storey house in a rural location with a separate attached one-bedroom self-contained apartment. Three residents live in the main house and the fourth resident live in the separate apartment. The centre provides a service for residents with an intellectual disability who require a high-support residential placement with full-time supervision.

How we gather our evidence

As part of the inspection, inspectors met three residents, the staff team including the team leader and the person in charge. Residents told inspectors that they liked the staff and living in the countryside, about what they enjoyed doing at work and the activities and interests they pursued in the community. Residents told inspectors about recent events and outings they had attended and what they had planned for the day and how they kept in contact with family members, where applicable.

Staff interacted with residents in a respectful, appropriate and supportive manner, as on previous inspections. Staff demonstrated that they knew residents well. Staff articulated that they had been receiving training and support from the multi-disciplinary team and that this enabled them to better understand residents' needs and support residents to pursue their interests and choices in a safe environment.

Overall judgment of our findings

Overall, inspectors found at this inspection that improvements made at the previous inspection were being further progressed and maintained. Reassurances had been sought at the previous inspection that adequate staffing arrangements would facilitate residents to participate in the community and pursue their interests and hobbies and inspectors found that this was the case in practice.

However, two outcomes remained at the level of major non-compliance at this inspection.

Under Outcome 5: Social Care Needs, the provider had made significant progress to address a key failing relating to the inappropriate mix of residents in this centre. However, as residents were living with or in close proximity to other residents that they had allegedly abused in the past, this failing will remain at the level of major non-compliance until it has been fully addressed.

Under Outcome 17: Workforce, inspectors found that minimum staffing levels required for the purposes of safeguarding residents and protecting them from abuse had not been maintained on two recent occasions. The provider was issued with an immediate action plan and responded adequately within the required timeframe. Staffing arrangements were also identified as a key failing on the two previous inspections.

Other non-compliances related to staff skill mix, risk assessment, monitoring of actions and restrictive practices. Findings are detailed in the body of the report and should be read in conjunction with the actions outlined in the action plan at the end of the report.

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 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:

Overall, actions identified at the previous inspections were being satisfactorily progressed. However, this outcome will remain at the level of major non-compliance pending implementation of the provider's relocation plan.

At previous inspections, inspectors found that the designated centre did not meet the assessed needs of all residents due to the inappropriate mix of residents in the centre. This inappropriate mix of residents had failed to provide adequate reassurance that residents would be protected from all forms of abuse. The timeframe for completion of this action was 31 July 2016.

The provider had outlined a plan to relocate some residents to a more appropriate setting. A transition plan had been completed for residents who would be relocating. While the timeframe for completion of this action had not been achieved, satisfactory progress in addressing the action was demonstrated. However, as residents were living with or in close proximity to other residents that they had allegedly abused in the past, this failing will remain at the level of major non-compliance until it has been addressed.

At the previous inspection, the individualized assessment of needs required completion. Since the previous inspection, assessments of needs for each resident had been completed and this action was completed within the previously proposed timeframe.

At the previous inspection, inspectors found that the link between assessments, planning for residents' future needs and other parallel meetings was not demonstrated.

In addition, the review of the personal was not multi-disciplinary. The timeframe for completion of this action was 30 June 2016.

At this inspection, inspectors reviewed the progress being made in relation to personal plans. A new personal plan model was being introduced and rolled out specific to residents' needs in this centre. Training to support the new model of personal plan had been delivered.

The person in charge and staff team had commenced development of the new plans. Multidisciplinary involvement was to be arranged as the next step in the process. While the development of the new plans were in progress, residents' goals had been updated in consultation with residents themselves. While the timeframe for completion of this action had not been achieved, satisfactory progress in addressing the actions was demonstrated.

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:

This outcome has reduced from major to moderate level of non-compliance since the previous inspection. Further improvement was required in relation to risk assessment and risk control.

At the previous inspection, inspectors found that the incident form did not document the learning and any preventative actions that were to be implemented to prevent recurrence. Examples of incident forms reviewed at this inspection demonstrated that this failing had been addressed.

At the previous inspection, an environmental restriction that had been in place for health and safety reasons had been removed during renovation works and there was no risk assessment in place that assessed the associated risk(s) and clearly outlined the interim controls in place. In addition, there was a unlocked gate leading to a side-road and there was no risk assessment in place that assessed the associated risk(s) and clearly outlined the interim controls in place.

A number of pot-holes were observed in the exterior area accessed by the resident in separate apartment. Since the previous inspection, these failings had been satisfactorily addressed. The premises works had been completed and adequate health and safety measures were now in place. There were no obvious health and safety hazards in or around the centre.

At the previous inspection, it was not demonstrated that risk assessments required for elevated risk situations had been completed. At this inspection, inspectors reviewed the risk register for the centre. The risk register had been updated to include centre-specific risks, such as in relation to staffing levels, safeguarding, transport, attendance at day services, outings and behaviours that may challenge.

Risks were being reviewed on a regular basis by the person in charge. However, further improvement was required in some areas. For example, the risk rating was not included for each risk and whether control measures in place were adequate or not was not clear. In addition, where control measures had proven to not be effective (in relation to staffing arrangements), this was not reflected in the risk assessment.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Overall, inspectors found that the provider had implemented a number of measures to protect residents from abuse. However, gaps were identified on this inspection relating to safeguarding arrangements, safety protocols and restrictive practices.

At the previous inspections, it was not demonstrated that residents were protected from all forms of abuse in the centre, including sexual, verbal, physical and psychological abuse. Residents were living with or in close proximity to other residents that they had allegedly abused in the past. Over the course of the two previous inspections, the provider had implemented a number of measures to address this failing.

At this inspection, the positive impact of measures taken were clearly evident. Inspectors spoke with staff, including relief staff, who were fully aware of safeguarding measures required while supporting residents in their day to day lives. Staff told inspectors that the additional supports that they had been receiving from the person in charge and multi-disciplinary team meant that they were "much clearer" on how best to support residents' specific needs in this centre.

In the short- to medium-term, suitable alternative accommodation was in the process of being secured to ensure a more suitable mix of residents in the centre.

At the first inspection of this centre, it was found that there were inadequate safeguarding arrangements in place, including staffing arrangements, to implement residents' safety protocols. Adequate re-assurance had still not been provided at the previous inspection that the number of staff was appropriate to ensure adequate safeguarding of residents at all times. At this inspection, adequate re-assurance was again not provided. Inspectors found that there had been two recent occasions whereby minimum staffing levels had not been maintained. The action relating to this failing is under Outcome 17: Workforce.

In addition, safety protocols required review. While safety protocols identified that line of sight supervision of residents was required, the minimum staffing levels required while residents were in the house together were not specified. Also, the protocol references staff being on duty or 'available' to provide such supervision, which was potentially open to misinterpretation.

At this inspection, inspectors observed an environmental restriction in place in the kitchen in the form of locked presses and drawers. No clear rationale for this restriction was offered or evident at the time of inspection. For example, the cutlery press was locked but knives and forks were laid out on the kitchen table, which had been set by residents themselves. In addition, the restriction had not been approved by the organisation's restrictive practices committee.

Also, the person in charge told inspectors that the restrictive practices committee had reviewed whether or not the fob-accessed bedroom doors constituted a restriction and determined that it was not a restrictive practice. However, documentary evidence of this review were not made available to inspectors for review in the centre on the day of inspection. In addition, other information relating to restrictive practices and use of single live-feed closed circuit television (CCTV) was not made available to inspectors for review. This will also be addressed under Outcome 18: Records.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

At the previous inspection, not all of the required information had been submitted to HIQA, as it related to restrictions in place.

At this inspection and as previously mentioned under Outcome 8, an environmental restriction had been introduced in the kitchen in the form of locked drawers and presses since the previous inspection. This restriction had not been notified to HIQA, as required.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Overall, progress had been made since the previous inspection in relation to ensure residents received the support they required from allied health professionals and members of the multi-disciplinary team (MDT). However, it was not clear how some referrals for assessments to support residents' needs had been progressed.

At the previous inspection, residents' required a number of assessments to support their needs. Psychological assessments were required for each resident, as recommended in a forensic risk assessment report dated March 2016. An assessment for a behaviour support plan was required for one resident, as recommended in the same report. In addition, a mental health plan for three residents was required, as identified by

residents' needs assessments. The timeframe for completion of this action was 30 June 2016.

At this inspection, inspectors found that the mental health plans were in an advanced stage of development and a programme to support mental wellbeing was being run by the psychologist. The person in charge told inspectors that psychological assessments had commenced. However, it was not clear how this action had been progressed.

Regarding the behaviour support plan, further clarity was required in relation to whether the MDT team was satisfied with the proposed timeframe and priority allocated for completion of the behaviour support plan. Issues as they relate to documentation will be addressed under Outcome 18: Records.

At this inspection, inspectors found that a care plan was not in place to support all residents' assessed needs, for example, in relation to promoting continence. However in practice, it was demonstrated that the residents' care needs as they related to healthcare were being met as residents had been seen by their doctor, consultants and nurses as required and recommendations were being implemented by staff. This will be addressed under Outcome 18: Records.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

This outcome was examined by a medicines management inspector.

At the previous inspection, it was identified that two prescription records were not complete prescriptions in accordance with the Medicinal Products (Prescription and Control of Supply) Regulations as each individual prescription was not signed and dated. On this inspection, all residents' prescriptions were reviewed and found to be complete prescriptions.

At the previous inspection, it was noted that, while the prescriber identified specific times for medicines to be administered on the prescription records, staff who administered medicines did not record the time of administration on the administration

records. On this inspection, all residents' administration records were reviewed and the inspector saw that the time of administration was not recorded on the administration records.

Therefore, it could not be confirmed that medicines were administered as prescribed. This was particularly important where the prescriber had identified specific times for medicines for heart conditions and diabetes which can have a potential moderate impact if the dose is delayed.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

At the previous inspection, improvement was required to the statement of purpose as the admissions criteria were too broad. The provider's response detailed that the Statement of Purpose will be amended when the relocation plan is finalised and the admission criteria will be streamlined.

This action will be carried forward for completion when following implementation of the relocation plan.

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):

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

Findings:

Overall, sufficient progress was demonstrated over the course of the previous two inspections to evidence that recommendations relating to meeting residents' need for a therapeutic and safe environment were being implemented or actively progressed.

At the previous inspection, it was found that formal structures were required to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Inspectors reviewed a recent unannounced provider visit, which examined progress being made as it related to actions and the safety and quality of care being provided to residents in the centre. Items that required follow-up were identified in an action plan.

For example, the need for on-going assessment of staffing arrangements and actions that had yet to be completed in full, such as the new personal plans and the need to follow up on the referral for a behaviour support plan were identified. However and as previously mentioned under Outcome 11, it was difficult to track some actions, such as in relation to referrals recommended in a forensic risk assessment report completed in March 2016.

In addition, the representative of the provider had not been informed of recent incidents whereby minimum required staffing levels had not been maintained.

At the previous inspection, it was found that monitoring recommendations contained in a forensic assessment report for the centre had yet to be implemented in full. Since the previous inspection, it was evidenced that these recommendations were being implemented and maintained. Monitoring recommendations being implemented included monthly risk management review meetings.

The recommendation for an annual meeting to review overall risk management was not yet due (the recommendation was made in a report dated 26 March 2016 meaning that the annual risk management meeting would not be required until March 2017).

At the previous inspection, it was found that medicines management audits were limited in scope. On this inspection, inspectors saw that audits in medicines management had been completed every month by the person in charge. However, the medicines management audits did not examine a number of areas in the medicines management cycle including ordering, receipt, review and disposal of medicines.

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:

At this inspection, it was found that there were inadequate staffing arrangements in place to implement safeguarding recommendations, including line of sight of residents at all times. In addition, the roster required review to ensure that there was an adequate skill mix of staff on duty at all times.

At the previous inspection, re-assurance was not provided that the number of staff was at all times appropriate to the number and assessed needs of residents, in accordance with forensic risk assessment recommendations and adequate to support residents' to fully participate in the community.

As discussed under Outcome 8: Safeguarding and Safety, there are minimum staffing requirements in this centre of two staff when the house is occupied by all four residents. However, inspectors found that there had been two recent occasions (on 15 July 2016 and 1 August 2016), when this requirement was not met and only one staff member was on duty. Inspectors found that a contingency plan was not in operation to ensure that any staff shortages were filled. In addition, the risk assessment in the risk register that related to staffing arrangements had not been updated to reflect these recent incidents. This was a significant failing as the minimum staffing requirements are based on risk assessment particular to this centre and are necessary for the safeguarding of residents and to protect both residents and staff from injury or harm .

At the close of the inspection, the provider was required to provide reassurance as to how any such occasions of staff shortages would be addressed should it arise again and an immediate action plan was issued. The provider responded adequately to the immediate action plan and submitted a contingency plan to HIQA within the required timeframe.

In addition, inspectors found that it was not demonstrated that the staffing roster had been planned in a way that ensured that staff on-duty had the required experience, skills and training to support the needs of residents in this centre. On the day of inspection, neither staff on-duty was part of the core staff group in this centre. While staff had worked in the centre on a relief basis on a few occasions or knew residents through the day service, it was not demonstrated that the planning of the roster had

considered what mix of experience, skills and training that staff required to support residents in this centre. In addition, one staff member required training in the protection of vulnerable adults and the second staff member required training in relation to positive behaviour support.

At the previous inspection, it was found that further training was to be completed in order to up-skill staff and ensure that they were provided with training specific to supporting residents in this centre. Since the previous inspection, the staff team had been provided with training, instruction and information to enable them to support residents needs and relevant to the specific risk profile in this centre.

Training/instruction included identifying specific indicators of risk, how and what relevant information to record, training in relation to the new personal planning model and supporting residents' mental health and wellbeing. There was evidence that recommendations made during such training were being implemented.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:
Use of Information

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

No actions were required from the previous inspection.

Findings:

Aspects of this outcome were included due to failings identified on the day of inspection.

Inspectors reviewed residents' files and found that not all records were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

As detailed under Outcome 8, not all documentation relating to restrictive practices in use in the centre was available for review by inspectors.

Inspectors reviewed minutes of monthly MDT and staff team meetings. In some instances, there was insufficient information in those minutes to demonstrate what had

been discussed at those meetings and what actions arose from the meetings. Some entries were unclear. For example, it was not clear what was meant by an action to be taken by an MDT member who was to revert to the behaviour support committee to consider options for one resident. In addition, not all items included on the agenda were reflected in the minutes of that meeting.

For example, items on an agenda for an MDT meeting in June 2016 that related to referrals for risk assessments and a behaviour support plan were not minuted so it was unclear whether they were discussed and if so, what action was required. As mentioned under Outcome 14, this made it difficult to track progress in relation to some actions.

Inspectors observed that a protocol to support a residents' continence needs was kept on the office notice board and there was no care plan in place in the residents' file. The residents' name was on the protocol and other residents were observed to be in and out of the office at different times with staff during the day.

Judgment:

Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Julie Hennessy
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 report¹

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
Centre ID:	OSV-0004579
Date of Inspection:	03 August 2016
Date of response:	26 August 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 05: Social Care Needs

Theme: Effective Services

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

A new model of personal plan was in under development, which would involve multi-disciplinary input. This process had yet to be completed in full.

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

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

The information gathering/mapping to inform the Person Centred Plans is now complete. The plans will be discussed at the next Multidisciplinary Team [19th September 2016] meeting and the PIC will finalised the plans with individual residents.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

The designated centre did not meet the assessed needs of all residents due to the inappropriate mix of residents in the centre. While this action was being actively progressed, it has yet to be completed.

2. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

1. A second Service Centre has been acquired and Purchase contracts are currently being finalised.
2. An amended application form will be submitted to the Authority to register this additional unit
3. Renovation work and fire compliance upgrades on this additional facility will commence as soon as possible to ensure registration can be progressed as a priority.

Proposed Timescale: 14/10/2016

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:

Improvement was required in relation to on-going assessment of risk and review of control measures in place.

3. Action Required:

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

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

A risk management workshop for all staff is scheduled for September 2016 to ensure all staff are updated on risk identification, assessment of risks, rating of risks and the risk management processes including elevation procedures.

Proposed Timescale: 30/09/2016

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:

An environmental restriction had been introduced in the kitchen in the form of locked presses and drawers. There was no clear rationale for this restriction. In addition, the restriction had not been approved by the organisation's restrictive practices committee.

Also, documentary evidence of this review by the restrictive practices committee of the fob-accessed bedroom doors was not made available to inspectors on the day of inspection.

4. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

The Person in Charge has removed the keys to the kitchen cupboards to ensure that these are not locked without approval. The PIC re-assessed the risks in relation to kitchen equipment and the possible need to keep some items in a secure cupboard. Based on this there are now no restrictions in the Kitchen area and this will be kept under review with the staff team.

Proposed Timescale: 04/08/2016

Theme: Safe Services

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

As detailed within the findings, safety protocols required review.

5. 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:

The Person In Charge has review all Safety Protocols to clarify terminology to ensure the implementation of the protocols is not open to misinterpretation.

Proposed Timescale: 25/08/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

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

An environmental restriction had been introduced in the kitchen in the form of locked drawers and presses since the previous inspection. This restriction had not been notified to HIQA, as required.

6. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

The Provider will issue a reminder to all Persons in Charge to ensure that all restrictions including the locking of kitchen sharps in a cupboard must be notified to the Authority in the quarterly returns. The Person in Charge will submit an amended Q2/2016 notification to the Authority in relation to this matter.

Proposed Timescale: 30/08/2016

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:

It was not clear how referrals for assessments to support residents' needs had been progressed. In particular, as they related to a behaviour support plan for one resident and risk assessments recommended for completion in a forensic risk assessment report in March 2016.

7. 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:

A new tracking system on referrals will be put in place i.e. the system will identify

- the reason for the referral and the source and urgency of the referral ,
- the clinical priority rating assigned by the clinician and
- and status/ progression of the referral

This will provide greater clarity to the Team in relation to referrals made to multidisciplinary supports.

Proposed Timescale: 16/09/2016

Outcome 12. Medication Management

Theme: Health and Development

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

The time of administration was not recorded on the medication administration records.

8. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

The current Medication Administration Records are under review and will be revised to ensure that the exact time of administration of the medication is recorded on the MAR Sheet.

Proposed Timescale: 16/09/2016

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:

This action has been carried forward for completion following implementation of the relocation plan:

Improvement was required to the statement of purpose as the admissions criteria were too broad.

9. Action Required:

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

The Statement of Purpose will be updated to reflect the additional Service Unit in the Centre. The exact admission and discharge criteria will be restated.

Proposed Timescale: 16/09/2016

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:

As detailed in the findings, it was difficult to track the progress being made against a number of actions.

Medicines management audits were limited in scope.

10. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

The Centre will introduce Action Management Record Sheets to be used in conjunction with the Risk Register. The PIC will ensure that actions identified from various sources [e.g. Provider Inspections, Inspections by Authority etc] are logged, updated and accessible in the Centre.

The Medication Management Audit has been reviewed to ensure that the checks carried out during the audit cover the entire cycle from prescription through to disposal of medications.

Proposed Timescale: 02/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

It was not demonstrated that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre for the following reasons:

The provider failed to ensure that adequate contingency arrangements were in place to meet minimum level of staffing required to safeguard residents at all times;

It was not demonstrated that the qualifications and skill mix of staff was appropriate to the needs of residents in this centre.

11. Action Required:

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

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

The Provider and the PIC has reviewed the current staff scheduling system to identify possible weaknesses at both staff rostering and actual roster working stages. A Protocol is now in place in relation the Roster Planning and Implementation stages. [4 August 2016]

New rosters and skill mix will be put in place with the introduction of the additional facility and additional staff are under recruitment for this purpose.

Proposed Timescale: 14/10/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

As detailed within the findings, not all records required for review were made available for inspection.

12. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

As referred in Action 10 above the Action Record Sheets will identify key supporting records to be held in relation to identified actions and checks will be undertaken to ensure these are available in the Centre. The PIC will review this system on an ongoing basis.

Proposed Timescale: 30/09/2016