Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003364
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	PJ Wynne
Support inspector(s):	Marie Matthews; Day 1 and Day 2
Type of inspection	Unannounced
Number of residents on the date of inspection:	43
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 4 day(s).

The inspection took place over the following dates and times

From:	To:
24 June 2015 11:00	24 June 2015 18:00
25 June 2015 08:50	25 June 2015 18:00
29 June 2015 09:00	29 June 2015 18:00
30 June 2015 09:15	30 June 2015 14:00

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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the second monitoring inspection of this centre. This inspection was unannounced. As part of the monitoring inspection the inspectors met with residents and staff members. Inspectors observed practices and reviewed the documentation including care plans, medical records, accident and incident reports, policies, procedures and staff files.

Forty three adult residents are presently living in the centre. Residents' ages at the time of this inspection ranged from 23 to 92 yrs old. The specific care and support needs of the residents varied from moderate to profound intellectual disabilities.

Additionally some residents have a physical/sensory disability and age related healthcare needs.

The campus consists of six units. Four units are located within the main three-storey building. Two units are bungalows located on the campus grounds adjacent to the main building. Two units accommodate males only. The four other units accommodate both males and females with occupancy ranging from seven residents to maximum of 11 residents. Residents are accommodated within units deemed most suited to where their needs can be met, for example the level of disability, elderly residents and those with behaviours that challenge. Five residents have moved to a community house since the last inspection.

The design and layout of the designated centre does not meet the individual and collective needs of all residents in a comfortable and homely way. The building is institutional in style and despite some modifications retains a number of dormitory like aspects of living which detract from person-centred care.

Good practice was found in the management of resident's healthcare. Staff were knowledgeable and responsive to the residents' physical care needs. There was evidence of referrals for medical investigations and treatment. There was timely access to general practitioners (GP) service. There were regular reviews of psychotropic medication.

A total of 16 Outcomes were inspected. The inspector judged six Outcomes as major non compliant. These included Governance and Management, Workforce, Health and Safety, and Risk Management. Residents Rights, Dignity and Consultation, Admissions and Contracts for Provisions for Services and Safe and Suitable Premises were judged as major non- compliant. A further seven Outcomes were judged as moderately non- compliant with the Regulations. The remaining two Outcomes were judged as compliant and substantially in compliance with the Regulations.

There was very limited progress from the action plan of the last inspection. The areas of major non compliance primarily related to the findings that there was a significantly poor level of compliance with mandatory training requirements in relation to fire safety and safe moving and handing techniques. Given the high level of non compliance with Regulation 28, Fire Precautions, the inspector issued an immediate action letter to the provider. This requires the matter to be addressed within a time frame specified by the inspector. Namely six weeks from the time of this inspection.

The operational management arrangements require renewed scrutiny to ensure a well led service. This inspection identified very visible gaps in the quality of life provided to residents. There was no real change in practice or evidence of progress to implement change since the inspection in October 2014.

There was inconsistency and variation in the standard of care practices across all units visited. The standard of risk assessment, care planning, understanding and implementation of personal goals varied.

Resident's independence was not promoted. There was limited evidence of residents having regular outings to go shopping, for a meal or celebrate special occasions.

There was evidence that staff actions did not always maintain resident's dignity and respect when carrying out personal care. Practice in physical care interventions by staff between units varied. A review of the staff rostering arrangements was not undertaken to ensure resources are allocated to where the need is most required.

The Action Plan at the end of the report identifies all areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

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

Theme:
Individualised Supports and Care

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

Findings:
The design and layout of the designated centre was institutional in style and despite some modifications, retains a number of dormitory like aspects of living. This restricts resident's choice. Not all residents had single bedrooms. Residents occupying double bedrooms were sharing with the same person for a long period of time and there was familiarity in each other's routines.

While some bedrooms were well personalised a number of bedrooms were very sparsely furnished. Soft furnishings to include curtains and duvets were of poor quality and not modern in design in some bedrooms. There was sufficient space in each bedroom to hold clothing and other personal belongings.

Meal time practices, with meals brought in heated trolleys, prepared in a centralised kitchen did not promote resident's independence and choice. They did not have the opportunity to be involved in meal preparation as part of an ordinary living environment.

Menu options were not promoted. While there were two options available only one meat choice was delivered to each unit. At the request of individual staff members an additional option was provided by the kitchen. Copies of the menu were not available on the unit. Staff and residents were only aware of the course being served when it arrived to the units. The choice for evening tea was selected and relayed to the central kitchen a day in advance.

All residents did not have the option of desserts on a daily basis. Kitchen and care staff told the inspectors all residents got a dessert only on Sunday, except for those on a fortified diet. No desserts were served to residents during the days of inspection. There were limited choices for residents in the evening time when the kitchen closed. Similarly as identified on the previous inspection the variety of the stock of food in the units was limited. There was a reliance on canned foods and cereals for late evening meals. There were limited cooking facilities to offer savoury snacks in the units in the evening time.

A number of residents were on a pureed diet due to swallowing difficulty. These meals were purchased in ready to eat. The inspector observed staff assisting residents with pureed meals. However, resident's choice was not promoted and their food preference assured. When asked by the inspector some staff were uncertain of the content of the pureed meal and type of food they were feeding to residents.

Meals times in each unit were not a social occasion and the customs around mealtimes were institutional in practice. Resident's independence was not promoted. Gravy was added to plates without consultation and no resident assisted themselves, for example to add milk or sugar to tea. The majority of residents wore white plastic aprons. In one unit visited two care staff were observed feeding two residents. They did not engage with the residents throughout the meal in any form of conversation. The plates were not placed on the table in front of the residents. The plates of food were held up high in the hands of the care assistants at all times while assisting to feed the residents.

The majority of staff interacted well and affection was evident between residents and staff. However, there was evidence that staff actions did not always maintain resident's dignity and respect when carrying out personal care. The inspector observed one resident being assisted in getting dressed. The care staff member did not engage in any conversation with the resident and continued to whistle while selecting clothes and assisting the resident to get dressed.

There was a complaints policy in place which is based on the 'HSE- Your Service Your Say'. However, there was not a local complaints policy in place to meet all the requirements of the regulations. A designated person was named to whom complaints could be made at a local level in the centre, as required from the action plan of the previous inspection report.

A second person was not nominated in the centre to ensure complaints are responded to and records maintained within the timeframes outlined. The complaints policy included an appeals process based on the 'HSE- Your Service Your Say'. If the complaint was not resolved within the centre, the complainant could bring their complaint to the HSE complaints officer. These details were not available in the complaints procedure on display on notice boards in each unit visited.

There was a central complaints log maintained to record any complaints from residents or their next of kin from all units. However, there was not a standardised form developed to record details of complaints, the investigation undertaken, action taken to resolve the issue raised and the complainant's satisfaction with the outcome. This led to variation in how complaints were investigated and responded to. The complainants' satisfaction with the outcome raised was not documented in all cases.

Judgment:
Non Compliant - Major

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

Findings:
The individual communication requirements of residents were outlined in their personal support plans. The communication profiles for residents described well their preferred routine in all activities of daily living, from getting up, dressed and having their meals and what they could do for themselves.

Each resident had a hospital passport completed to outline all their required information in the event of a transfer to an acute hospital. A communication strategy was developed for all residents by the speech and language therapist.

However, some of the communication strategies were developed in 2010 and not reviewed by an allied health professional to take account of changes in health status. One resident with a diagnosis of multiple sclerosis whose speech had deteriorated did not have his communication prolife updated. A small number of residents have a diagnosis of dementia. While their nursing communication care plan was reviewed their communication strategy by a speech and language therapist was not updated.

By virtue of long standing relationships the staff understood the resident's preferences and the meaning behind their non verbal communication. However, there was limited availability of pictorial communication aids. Some staff were deployed to different units to cover staff absences. In some instances the inspector observed difficulty for some staff to understand resident's preferences and the meaning behind their non verbal communication as they did not regularly work on the unit.

Judgment:
Non Compliant - Moderate

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 had access to an advocate. A photograph was available of the advocate alongside information on advocacy. However, the name of the advocate was not on the photograph. Some staff on some units were unable to identify the advocate to the inspector on the notice board.

There was a room available to residents to meet with visitors in private. However, it was not well furnished and appeared multi functional in purpose. It only contained a table and some chairs. The room was not decorated with suitable soft furnishings or facilities for refreshments to support a positive visiting experience.

In two of the units there was good evidence of links established and supported contact between residents and their families. Some of these residents visited home for regular overnight stays. At the time of this inspection the service had rented a house in a local seaside town for three weeks. Some day trips were undertaken during the days of inspection. Other outings were being planned over the coming weeks.

The transport system arrangements were not adequate or suitable to meet residents' needs. Two drivers are employed each week, Monday to Friday and not at the weekends. During week days the buses are used to bring people who live in the community to their day service and consequently not readily accessible to residents on the campus.

The shift rostering of bus driver's limits resident's opportunities for social recreation away from the centre and to fulfil the goals of their personal plans. Only three staff members have an appropriate drivers licence to drive the larger wheelchair accessible bus when the bus drivers are off duty at weekends. There was limited evidence of residents having regular outings to go shopping, for a meal or celebrate special occasions.

Judgment:
Non Compliant - Moderate

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

Findings:
The centre's Statement of Purpose states 'emergency admissions cannot be accepted as the centre is operating at full capacity'. Furthermore, in line with the national agreed policy 'Time to Move on from Congregated Settings' the service is striving to work towards the ethos of this national policy and its strategy for community inclusion.

However, an individual was admitted to the service in the past month on an emergency basis. Prior to the previous inspection a new resident was admitted to the service and remains in the service currently. The inspector was informed both admissions occurred as there are no community facilitates or resources for family emergencies or to meet crisis needs.

The most recent resident admitted has required a significant amount of one to one care. This has had an impact on the lives of the residents currently accommodated in the unit due to limited staff resources.

A copy of the contract of care was retained in each file examined and a copy was sent to the nominated next of kin. A review of the contracts of care is required to ensure both parties have signed each copy. In the sample reviewed one was not signed by the resident's next of kin.

The contracts detailed the total fee payable. However, the detail of any service that may incur an extra cost was not outlined the contract of care for example hairdressing and chiropody. Some residents pay additional charges for reflexology treatments and massage therapies this is not identified within the contract.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The inspector met with the majority of residents and reviewed a selection of their personal plans. Resident's files contained information that outlined their health, intimate and personal care needs along with their family contacts and relationships. Risk assessments were completed to inform care planning and detailed interventions in relation to identified needs. These included behavioural challenges, supports and medical issues.

Each resident had a plan outlining their personal goals for the year. However, it was difficult to establish when goals were initially set as only a review date was identified. The objectives of some of the goals of personal plans are very limited and not linked appropriately to aspirations.

There was limited evidence available in relation to how the goals were chosen for some individual residents. In addition many goals referred to one off activities, or everyday activities of living, rather than developmental goals. There was no a clear understanding by staff in some cases of the true meaning of goals. In one file reviewed 'to have a broken lava lamp repaired' was identified as a goal. Other examples of goals read by inspectors included maintaining the current level of service to individual residents; i.e. 'to continue to have reflexology' or 'more frequent bus spins'.

Where goals were identified individual staff members were not named to take forward objectives in the plan within agreed timescales. All staff were identified as responsible, although each resident was assigned a named nurse and key worker. The progress being made in achieving goals or the reason why goals were not reached was not documented. No support plans were outlined to help residents achieve their goals.

A review of the personal plans for residents identified the need for improvement in the promotion of individualised goal setting for residents taking account of their capacities and life stage. Only in a very limited number of files reviewed were new goals identified for 2015.

Only in a very small number of personal plans were photos available showing residents engaging in their identified goals. There was no use of assistive technology, aids or appliance for example, digital photo frames to promote residents full capabilities in their personal care plan or assisting to communicate their aspirations.

There was evidence of multi disciplinary review of personal plans and family involvement. However, the inspectors identified some personal plans were not reviewed within the annual time frame. One resident's personal plan was not reviewed since 2013.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The campus consists of six units providing accommodation for a maximum of 43 residents. Four units are located within the main three storey building and two units are located on the campus grounds adjacent to the main building. Two units accommodate males only. The four other units accommodate both males and females with occupancy ranging from seven residents to maximum of 11 residents. Residents are accommodated within units deemed most suited to where their needs can be met best, for example the level of disability, elderly residents and those with behaviours that challenge. Residents have a good range of assistive equipment. Five residents have moved to a community house since the last inspection.

An increased number of residents have single bedrooms since the last visit. However, the design and layout of the designated centre does not meet the individual and collective needs of all residents in a comfortable and homely way. The building is institutional in style and despite some modifications retains a number of dormitory like aspects of living which detract from person centred care. There are 26 residents accommodated in single bedrooms and seven twin bedrooms. Each resident had a minimum of wardrobe and bedside locker as storage space for their belongings. Others had chest-of drawers and additional shelving. Some bedrooms were sparsely furnished with furniture worn and poor quality curtains and duvets.

The communal areas in some units were not located close to resident's bedroom accommodation and they did not have the option to return to their bedrooms during the day. In one unit the residents' dining room and day sitting rooms were on the ground floor. Residents did not return to their bedroom until night time as staff were deployed on the ground floor to meet their needs. In another unit while the bedrooms were on the same floor as the day communal areas they were separated by a long corridor. Residents could not move easily between the two areas and did not have good access to their bedrooms during the day.

Some routines for showering were dictated by the number and location of bathrooms. While there were adequate numbers of showers/baths, some of these were dormitory in the style of layout. Some bathroom facilities contained either two or three wash hand basins or two or more toilets enclosed with a cubicle. Residents' privacy was not ensured as some cubicles were not partitioned all the way to the ceiling. These matters were identified on the previous inspection.

The layout and configuration of some units does not facilitate choice and meet residents' needs. On this visit it was identified three males residents were reallocated to different bedrooms to ensure they could be safely evacuated in the event of a fire. One bedroom was previously used as a kitchen and the cupboards had not been removed. The wardrobes containing residents clothing had not been removed from the bedroom previously occupied to their new bedroom areas. The day sitting room and dining room used by the residents in this unit was at the opposite end of the building. One resident needed to rest during the day. However, he was not facilitated to return to his bedroom as it was too far away from the communal day sitting room for staff observation to ensure his safety. A bed was provided in a room located off the day sitting room the inspector was informed for the resident to rest during the day.

All parts of the building were maintained visually in a very clean condition. The standard of décor between the units varied. One unit, where the more elderly residents are accommodated was refurbished and the décor is of a very high standard and bedrooms are very well personalised, comfortable and homely.

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
The systems and procedures in place to promote the health and safety of residents, staff and visitors required review. There are corporate HSE polices in relation to health and safety, risk assessment and incident reporting. An evidence-based risk assessment tool was available for use. Documented procedures to guide staff responses to events such as aggression, violence or the unauthorised absence of a resident were in place.

On the last inspection, the inspector reviewed an incident of challenging behaviour in which an injury was sustained by a staff member. The inspector identified staff were not

issued with emergency alarms for use at night time to summon assistance if required while lone working. The residents in this unit have since moved to the community. However, it was identified in one other unit there is only one care assistant on duty throughout the night. This staff member was not provided with an alarm to summon assistance if help was required urgently. The systems to ensure learning to minimise the risk of repeat occurrence of similar incidents between units is not robust and requires review.

A summary of risk form is completed for residents and forwarded by nursing staff for review by clinical nurse mangers. This information is used to collate a monthly report for the person in charge. There were examples of referral to psychiatry or review by the GP on escalating incidents. However, the form requires review to provide more qualitative information to allow for the identification of trends. Some incidents are described as clinical and it is unclear whether they describe weight loss, pressure wounds or acute illness. The monthly form identifies each unit. However, the information does not correlate the number of incidents to each resident to readily identify a pattern associated within a particular unit or issue with an individual resident.

Fire safety equipment including the fire alarm, fire extinguishers, emergency lighting and smoke detectors were provided and were serviced quarterly and annually as required. The fire action notices describing the action to take on discovering a fire were located on corridors. However, the print was small and some have been in place since 2004. Weekly fire safety checks were completed to ensure exits were unobstructed, fire extinguishers were in place and intact and fire alarms and automatic door closers were operational.

On the last inspection staff participation in fire drill practices had commenced. The outcomes of the fire drills were being used to develop a personal evacuation plan for each resident. At the time of this inspection each resident had a personal emergency evacuation plan in place. They detail the equipment required to safely evacuate the resident. However, they require review as they are not all based on learning from residents response to fire drills. Regular simulated fire drill practices were not taking place.

The action required from the previous inspection report to ensure all staff are suitably trained in fire prevention, emergency procedures and arrangements for evacuation was not completed. At the time of this inspection only 38% of the nursing staff and 45% of the care assistants had fire safety training within the past 12 months. A review of the night duty roster for two nights indicated two of the eight staff were not trained. Two other staff did not have refresher training since 2011 and 2012 respectively. The third staff member did not have refresher training in over a two year period. Twenty two residents sleep on the first floor of the building. Given the high level of non compliance with Regulation 28, Fire Precautions, the inspector issued an immediate action letter to the provider. This requires the matter to be addressed within a time frame specified by the inspector.

Due to the dependency of residents hoists were required by staff to assist with moving and handling some residents in a safe manner. A moving and handling assessment was completed in all cases. There was evidence of good input from the occupational

therapist in the moving and handling assessment. However, all staff did not have refresher training in safe moving and handling of residents as their current certificate of training had expired. Records reviewed indicated only 43% of nurses and 29% of care assistants had up to date training.

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):

Findings:
Two notifiable adult protection incidents which are a statutory reporting requirement to the Authority occurred and were reported since the last inspection. Measures to ensure residents were fully safeguarded were in place. Social workers were informed and involved in the multi disciplinary review and outcome resolution.

Staff to whom inspectors spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. The policy of the service is to ensure all staff have annual refresher training in the safeguarding of vulnerable adults. Further work is required to ensure all staff have up to date training during 2015.

Intimate care plans were in place for all service users. Nursing staff are assigned as key workers with responsibility to complete a number of plans each. However, some intimate care plans were not reviewed annually in the sample of files examined.

Inspectors found that the system for management of residents' money was transparent and accountable. All monies given to or for residents' use were dated and the expenditure was recorded and receipted by the finance office on site. There were two staff signatures in place in each resident's financial records book on the units. There were policies and procedures to guide practice where the provider acts as agent for residents in conjunction with the Department of Social Protection.

The model of behaviour management utilised by the centre was clearly defined in the policy for positive behaviour support. The policy includes a pathway for reviewing risk in relation to increased behavioural issues.

Each resident identified with behaviours that challenged had a behavioural support plan in place. The plans were developed in conjunction with staff and the behaviour support therapist. The care plans were well personalised to identify triggers and outlined preventative and reactive strategies on the interventions to take to ensure the safety of the resident. The number of days the behavioural support therapist is available has decreased since the last inspection. A number of behavioural support plans were past their annual review date. One resident newly referred in April was not seen by the behavioural support therapist at the time of inspection.

The inspectors reviewed aspects of restraint management practices. These were either physical, mainly bedrails or the use of splints by one resident or pharmacological, in response to escalation in a resident's behaviour which posed a risk to the resident's own safety.

In care files examined there was evidence of good practice in planning and responding to aspects of restraint management and to situations. A regular multi disciplinary review for the use of splints by one resident to minimise the risk of self harm was undertaken regularly. The occupational therapist, psychologist, behavioural support therapist and nursing team formed part of the multi disciplinary review meetings. Alternative options were being explored and trialled. The outcome of the last meeting resulted in a new type of splint which is less restrictive being considered.

A small number of residents had two bedrails raised. A risk assessment was completed and regularly reviewed to include the occupational therapist. A number of residents had ultra low beds with crash mats as an alternative to bedrails.

Psychotropic medications used were pertinent to specific behaviours and seen to be closely monitored by the prescribing clinician and regularly reviewed to ensure optimum therapeutic values.

The inspectors noted from reviewing staff training records that training in the management of behaviour that is challenging including de-escalation and intervention techniques had not been provided to all staff. This was an area identified for improvement in the action plan of the previous inspection report.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Progress has being made in the area of identifying meaningful activities for residents during the day. On the previous inspection it was noted many residents did not have the opportunity for meaningful engagement throughout the day suitable to their capacity and life stage.

The conversion of the unit which became vacant when five residents moved to the community to a day service has been a significant positive development in the lives of many residents. As many as 27 residents attend the service at least twice a week. Further investment is required to expand the level and frequency of service to residents taking account of residents' ability and life stage. Some residents continued to lead a very passive lifestyle and there were limited options for meaningful engagement throughout their day.

Although in the early stage of development investment is required to enhance the physical aspects of the unit to ensure a suitable sensory environment. The walls are presently all the same colour. The sensory room requires further development with the provision of suitable lighting. Additional equipment and materials are needed to enhance the facility and ensure adequate resources for meaningful engagement.

The service was resourced by one full time and one part time staff member. The activity staff are supported by care staff who accompany residents from the units they live on. Training in provision of activities was identified by the inspector as a requirement to support the staff leading the service to ensure opportunities to participate in activities suitable to residents' interests, capacities and development needs. Training in activity provision of the facilitators of the day service is required so they can guide care staff accompanying residents and maximise the experience to enhance their quality of life.

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:
Nursing staff were knowledgeable and responsive to the healthcare needs of residents. There was evidence of referrals for medical investigations and treatment. There was timely access to (GP) service, including out-of-hours.

Residents had access to social workers, speech and language, occupational therapy, psychiatry, dental and chiropody services. Access to appropriate treatments and allied therapies was available to residents. The inspector reviewed evidence of one resident attending a memory clinic for review by a clinical nurse specialist in dementia. Another resident with poor skin integrity was reviewed as required by a clinical nurse specialist in wound care.

Three monthly evaluations of nursing care plans as required by the centre's procedures did not always take place. Some care plans to meet a nursing need were not reviewed for an eight month period. There was a variation in the standard of care planning between all units. There were some good examples of plans of care being updated to take account of the reviews by allied health professionals. However, practice was inconsistent. One resident with a behavioural support plan was reviewed by the behavioural support specialist in November 2014. The nursing plan was not updated to reflect the outcome of the review.

There was evidence residents had been referred to a dietician and their recommendations were updated into care plans. Residents with swallowing difficulty were reviewed by the speech and language therapist. Staff were familiar with the different types of modified diets required by residents and could describe well to the inspector how their individual dietary needs are met.

There was a nutritional policy in place. There were three residents with a percutaneous endoscopic gastrostomy (PEG) feeding system in place. All residents were weighed monthly. An evidence-based nutritional risk assessment screening tool available for use. The menu was reviewed by the dietician to ensure it was nutritionally well balanced. However, as identified previously in this report, menu options were not promoted.

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

Findings:
There was a medication management policy in place. However, it was not updated as required by the action plan of the last inspection report. The procedure for ordering medication in practice was not reflective of the policy.

An assessment was undertaken to ascertain if a resident had the capacity to manage their own medication safely. However, the assessments require review as they were not revised in some cases for a significant timeframe.

The inspector reviewed a sample of drugs charts. The prescription sheets reviewed did not ensure clarity. The kardex' were not always legible and pose a risk of potential medication error. In particular when staff are deployed to a unit to cover holiday or sick leave and they are unfamiliar with the residents and their medication. The specific information was not always detailed in the correct column. In some cases new drugs were added to the bottom of the sheet for PRN (as required) medication outside of the columns.

As identified on the last inspection the times on the administration sheets recorded the medications being administered between 8:00 am and 9:00 am. However, the inspectors observed medications being administered at later times. While new administration kardex were printed they were not in use for all residents on each unit.

Each drug prescribed was individually signed. Controlled drugs were checked at the change of each shift and signed by two nurses in line with best practice. This was an area identified for improvement on the last inspection.

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:
A written statement of purpose was available. The statement of purpose submitted required review to reflect changes in the centre. The areas requiring review include;

A new person in change has been appointed.

The service and facilitates have changed with the closure of one unit as residents have moved to a community house and the unit is now used to provide a day service.

Apart from the management team the staffing complement does not require each staff members name to be identified.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
A new person in charge has been appointed since the last visit by the Authority. At the time of this inspection the person in charge was only in post for three weeks. The person appointed fulfils the criteria required by the Regulations in terms of appropriate qualifications and management experience.

The person in charge is supported in his role by two CNM's 2 and one CNM 1. The inspectors found that lines of authority were established and reporting relationships were understood by all staff. The appointed person in charge discussed with inspectors the challenges of the service and the work he has undertaken to date to familiarise himself with the care pathway delivery model.

This inspection identified very visible gaps in the quality of life provided to residents. There was no real change in practice or evidence of progress to implement change since the inspection in October 2014. Audits of the service were undertaken by management. However, there was no constructive action or support plan developed to work to address

findings. As identified on the last inspection the content of the personal plans indicates that further monitoring of practice is needed.

There was not a clear understanding by all staff of the true meaning of goals within personal plans as identified in Outcome 5, Social Care Needs. This was identified as an area for improvement on the last inspection. Staff were not supported by management through supervision and resources to implement social as well as health care plans for residents suitable to the complexity of the resident needs as required by a previous action plan.

There was a significantly poor level of compliance with mandatory training requirements in relation to fire safety and safe moving and handing techniques identified on the last visit. Very limited progress has been made in the intervening months since the last inspection to ensure all staff are trained. Attendance at some fire training sessions scheduled was very low. There was no constructive supervision by management to respond to the poor attendance at training organised.

There was inconsistency and variation in the standard of care practices across all units visited. While there was responsiveness to medical needs the standard of risk assessment, care planning, understanding and implementation of personal goals varied.

Practice in physical care interventions by staff between units varied. The rationale underpinning the staff deployment model is not apparent. A review of the staff rostering arrangements was not undertaken to ensure resources are allocated to where the need is most required. This was an area identified for improvement on the previous visit.

Judgment:
Non Compliant - Major

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 allocation of adequate resources to ensure an effective service to support and deliver a good meaningful quality of life for residents was not evident.

The transport systems and resource allocation impacts resident's accessibility to day outings. There was limited evidence of residents having regular outings.

Further investment is required to expand the availability and quality of a day service to residents. Investment is required to enhance the physical aspects of the unit being developed as a day service. There was a limited equipment and craft material available to ensure adequate resources for meaningful engagement.

Care assistant staff were not trained in the administration of emergency medication in the event of a seizure by a resident. In one unit the nurse had to leave to accompany a resident with a diagnosis of epilepsy return to the centre on the bus. Considering there is an insufficient nursing staff available this places additional pressure on limited nursing staff resources and restricts opportunities for outings by residents.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
The issues identified on the last inspection in the deployment of staff in terms of where the need is most required remains unresolved. The rationale underpinning the staff deployment model is not apparent. The inspector examined staff rosters, reviewed residents physical care and psychosocial needs and interviewed staff to discuss their roles, responsibilities and working arrangements.

As described in the previous inspection report in one unit accommodating five male residents there was one nurse and one care assistant rostered during the day or two care assistant. Four of the residents attended a day service most days of the week. On one of the days of inspection a staff member was called in from a community house to cover sick leave to ensure there were two care staff in this unit while only one resident was in the house. The resident has medium dependency care needs and goes unaccompanied on frequent walks around the campus.

In the adjacent unit seven residents are accommodated with complex care needs and high levels of dependency. Four residents require the use of a hoist for moving and handling. One resident requires intensive nurse care with complex medical needs and

skin integrity issues. There is only one nurse assigned to this unit during the day and two care assistant until 17:00. One care assistant leaves the unit for approximately an hour in the morning and in the afternoon to assist other residents on the bus journey to their day services. One of the regular care assistants was redeployed to another unit as a student nurse was on work placement in the unit for a period of three weeks. This practice does not ensure continuity and familiarity of care for residents and places additional pressure on current regular staff.

The nurse on duty in this unit is required to leave the unit to administer medication to residents in the adjacent unit at intervals throughout the day. The inspectors found the resources allocated to this unit very limited to adequately meet care and welfare needs. Additionally on the first day of this inspection a nurse on the ground floor of the building where 11 residents are accommodated was required to provide nursing cover to another unit accommodating nine residents. Therefore one nurse was required to ensure clinical supervision and administer medications to 20 residents in total during the work shift. While on the first floor one nurse and one care assistant were allocated to a unit to provide care for three residents. As discussed under Outcome 14 Governance and Management, and taking account of the aforementioned examples the clinical governance and operational management are not robust and require review.

The number of care assistants was inadequate and their deployment model considering the layout of the building and did not facilitate person-centred outcomes. There was evidence in one unit residents did not have the choice to return to their bedrooms throughout the evening at their leisure until a care assistant was available at 21:30 hrs to assist residents to their bedroom accommodation which was located on the first floor as described in Outcome 6, Safe and Suitable Premises. The inspector observed residents accommodated in their bedrooms on the first floor in the morning time awaiting staff to assist them to the day room. The residents were fully dressed. Those immobile were seated in their transport chairs with the door of the bedroom closed. One resident was heard calling out and observed to pull at the curtains while waiting to be moved to the day room.

There was an insufficient bank of nursing and care staff available to adequately meet resident's needs and ensure continuity of care. In one unit accommodating residents with behaviours that challenge the need for familiar staff to work alongside residents was identified. However, this did not always occur due to limited staff resources to adequately cover sick leave and holiday absences.

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

Findings:
The inspector reviewed a selection of staff files. The files were noted to contain all documents as required under Schedule 2 of the Regulations.

A directory of residents was maintained in each unit. The directory contained all of the matters required by 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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Health Information and Quality Authority

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003364
Date of Inspection:	24 June 2015
Date of response:	31 July 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Meal time practices did not promote resident's independence and choice. The customs around mealtimes were institutional in practice.

The majority of residents wore white plastic aprons.

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

While there were two options available only one meat choice was delivered to each unit.

Copies of the menu were not available on the unit.

Staff and residents were only aware of the course being served when it arrived to the units.

The choice for evening tea was selected and relayed to the central kitchen a day in advance

In one unit care staff were observed feeding two residents. They did not engage with the residents throughout the meal in any form of conversation. The plates were not placed on the table in front of the residents. The plates of food were held up high in the hands of the care assistants at all times while assisting to feed the residents.

Staff actions did not always maintain resident's dignity and respect when carrying out personal care. The inspector observed one resident being assisted in getting dressed. The care staff member did not engage in any conversation with the resident and continued to whistle while selecting clothes and assisting the resident to get dressed.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
The majority of residents wore white plastic aprons.
• The practice of wearing white plastic aprons will be discontinued. Suitable alternatives are currently being sourced. Compliance in respect of this practice will be audited and verified no later than 4th September, 2015.
Person responsible :PIC

While there were two options available only one meat choice was delivered to each unit.
• Meal choices now have three options including two meats and one alternative. This is to exercise choice in accordance with the resident's preference. Verified as of Monday 10th August, 2015 with a commitment to a weekly monitoring process.
Person responsible :PIC

Copies of the menu were not available on the unit.
• Copies of the menus will be available on each unit which will include food value content and will be in pictorial format. This action requires the input from a Nutritionist. Nutritionist commenced this work as of week of the 27th July with a view of completing this work as of the 15th September, 2015.
Person responsible :PIC

Staff and residents were only aware of the course being served when it arrived to the units.
As of the 13th July, 2015 staff were made aware that choice of course would be discussed with the service users and the kitchen based on preparing the advanced menus for each unit area. This practice will be audited and verified no later than 11th September, 2015.
Person responsible :PIC

The choice for evening tea was selected and relayed to the central kitchen a day in advance.
• Choice of evening tea will be selected on the day by residents. This has commenced since the 13th July, 2015. This practice will be audited and verified no later than the 11th
Person responsible :PIC

• Management will support staff to ensure that each resident's privacy and dignity is respected in relation to but not limited to his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. This will be audited and verified no later than the 11th September, 2015.
Person responsible :PIC

• The Service have fully embraced the principles of "Time to Move on from Congregated settings". This is evident by the fact that 38 people have successfully transitioned to community settings since 2004 and remain very connected to their respective community areas. To continue progressing the principle of "ordinary people living ordinary lives" as directed under the Policy "Time to Move from Congregated Settings project" 12 campus residents have been identified for the next phase. This phase will entail a full PCP review in consultation with these individuals, their guardian/family and or advocate no later than the 15th September, 2015. This process will support the resident's rights to access community living in accordance with their wishes and preferences.
• To support this process a submission for accommodation support has been furnished to the national Congregated Settings Action Group.
Person Responsible: PIC

Promoting and respecting residents while supporting them with their meal times and other areas of need.
• PIC in conjunction with local Team Manager have met with employees as of 30th June to outline the precise details of the specific aspects of their practice that was evident during the recent inspection of the service. Having made the staff aware of the gaps in their practice appropriate action has taken place to achieve the required outcome. This was followed up by the PIC in July and will be reviewed again by the 15th September, 2015. Supervision of this aspect of practice has been increased to ensure respect for residents is assured.
Person responsible: PIC

Proposed Timescale: 15/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resident's choice was not promoted and their food preference assured. Staff were uncertain of the content of the pureed meal and type of food they were feeding to residents.
Residents did not have the option of desserts on a daily basis.

There was a reliance on canned foods and cereals for late evening meals. There were limited cooking facilities to offer savoury snacks in the units.

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

Please state the actions you have taken or are planning to take:
• The service will ensure that each resident has the freedom to exercise choice and control in his or her daily life. Resident's choice will be promoted through pictorial menus for dinner and evening teas, desserts are now available daily and will be included on the daily menu. More choice will be available for late evening meals. This will be audited and verified on the 15th September, 2015.
Person responsible - PIC

• All Service Users and staff are informed of the content of the pureed meals. This practice is audited and verified and all meals are labelled.
Person responsible :PIC

• The Nutritional Committee met in July, 2015 which reviewed and made recommendations to improve store cupboard options for late evening meals to support that each resident is enabled to exercise choice in accordance with their own preferences. The store cupboard options have changed to reflect choice for each resident in accordance with their preferences as identified within each PCP. This practice is monitored on a weekly basis by the local/Unit Team Leaders.
Person responsible - PIC

Proposed Timescale: 15/09/2015

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of bedrooms were very sparsely furnished. Soft furnishings to include curtains and duvets were of poor quality and not modern in design in some bedrooms. Some were old and had not been replaced for a long time.

3. Action Required:
Under Regulation 12 (2) you are required to: Ensure that, as far as practicable, residents can bring their own furniture and furnishings into the rooms they occupy.

Please state the actions you have taken or are planning to take:
• New furniture was purchased in July in all units. Soft furnishings are currently been purchased for identified rooms. All residents are involved in exercising their own choice and preferences in decorating their own rooms. This practice has been identified by the local team leaders as an activity that will promote the residents independence and community participation. This is verified as goal within the Person centred plan for each person. To ensure all residents are fully involved this outcome will not be achieved until the 1st October, 2015.
Person responsible :PIC

Proposed Timescale: 01/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not a local complaints policy in place to meet all the requirements of the regulations. A second person was not nominated in the centre to ensure complaints are responded to and records maintained within the timeframes outlined.

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

Please state the actions you have taken or are planning to take:
• The service has nominated a person other than the person nominated in regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained. To ensure that this outcome is achieved realistically for persons with communication support needs the person nominated is skilled in understanding how to effectively enable these individuals to have their complaints heard. This will be achieved by diverse systems that will augment the resident's communications abilities. Individual communication requirements will be highlighted in the residents PCP's to inform the nominated person in this regard.
Person responsible : PIC

•The Complaints and Communication policies will be updated and be centre specific to reflect the changes To facilitate the changes a lead in period is required to ensure the nominated person is fully prepared to take this role on in a meaningful way.
Person responsible : PIC

Proposed Timescale: 31/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
If a complaint was not resolved within the centre, the complainant could bring their complaint to the HSE complaints officer. These details were not available in the complaints procedure on display on notice boards in each unit visited.

5. Action Required:
Under Regulation 34 (2) (c) you are required to: Ensure that complainants are assisted to understand the complaints procedure.

Please state the actions you have taken or are planning to take:
The service will ensure that the Service Users will be assisted in understanding the complaints procedure. This action will be the responsibility of the nominated complaints officer and the newly identified nominated person(as referred to above under outcome number 1) assisted by input from Speech and Language Therapist [SALT].
• The complaints procedure will be amended and displayed in all units and in an easy read/pictorial format to aid better understanding and comprehension for residents and for staff who will support them. This action will be completed by 30th September, 2015.
Person responsible - PIC

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not a standardised form developed to record details of complaints, the investigation undertaken, action taken to resolve the issue raised. This led to variation in how complaints were investigated and responded to.

6. Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
• The service will provide an effective complaints procedure for Service Users which is in an accessible and age appropriate format and includes appeals procedure. This action will be addressed within the updated Complaints and Communication Policies.
Person responsible - PIC
• There will be a standardised form to record details of complaints, the investigation undertaken and the action to resolve the issue. This form will need to reflect individual's communication needs.
Person responsible - PIC

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complainants' satisfaction with the outcome raised was not documented in all cases.

7. Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
• The service will ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process. An audit tool will be developed to measure how effective this action is achieved.
Person responsible - PIC

Proposed Timescale: 30/09/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the communication strategies were developed in 2010 and not reviewed by an allied health professional to take account of changes in health status.

8. Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
• The service will assist and support each resident at all times to communicate. To ensure that the service is adequately supporting the residents in a realistic and meaningful way the Speech and Language therapist will commence as of the 28th September, 2015 a full review of communication strategies utilised in the service to support the residents. This review process may take up to 5/6 months.
Person responsible - PIC

Proposed Timescale: 29/02/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was limited availability of pictorial communication aids. Staff were observed to have difficulty understand resident's preferences and the meaning behind their non verbal communication as they did not regularly work on the unit.

9. Action Required:
Under Regulation 10 (3) (c) you are required to: Ensure that where required residents are supported to use assistive technology and aids and appliances.

Please state the actions you have taken or are planning to take:
• The service will ensure that where required residents will be supported to use assistive technology and aids and appliances. The Speech and Language Therapist will direct and guide the residents PCP in this regard. This action will commence as of September 30th 2015 with the SALT.
Person responsible – PIC

• Staff will be deployed in units so that they can build meaningful relationships with all residents and understand their needs as expressed through augmentative language systems or other non verbal systems. This is to assure the residents that all staff understands their communication support needs. Team leaders will be required to induct and monitor all staff. This action was implemented as of 21st July 2015. This has and will continue to be monitored as a verified practice by local team leaders.
Person responsible - PIC

Proposed Timescale: 29/02/2016

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

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The visitors' room was not well furnished and appeared multi functional in purpose. It only contained a table and some chairs. The room was not decorated with suitable soft furnishings or facilities for refreshments to support a positive visiting experience.

10. Action Required:
Under Regulation 11 (3) (b) you are required to: Provide a suitable private area, which is not the resident's room, to a resident in which to receive visitors, if required.

Please state the actions you have taken or are planning to take:
• The service will provide a suitable private area, which is not the Service Users bedroom for the Service User to receive visitors in. Furniture has been purchased and this new facility will be opened as of 30th September 2015. To promote and support a positive visiting experience there will be refreshments available to residents for their visitors.
Person responsible - PIC

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was limited evidence of residents having regular outings to go shopping, for a meal or celebrate special occasions. The resource allocation for transport impacts resident's accessibility to day outings. Only three staff members have an appropriate drivers licence to drive the larger wheelchair accessible bus.

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

Please state the actions you have taken or are planning to take:
• The service will support Service Users to develop and maintain personal relationships and links with the wider community in accordance with their wishes. The service will review staff resources and allocations in order to further develop Service Users links with the wider community. Community participation will be guided by the Person Centred Planning Process and goals will have a community focus.
Person responsible - PIC

• Regular outings are now part of the normal daily routines where appropriate. This was initiated as of 21st July 2015 and is monitored by local team leaders and recorded within the residents PCP.
Person responsible - PIC

• A business case for purchase or rental of transport will be submitted to the General Manager by 28th August 2015. In addition a business case will be submitted to the General Manager for funding to train staff to acquire the appropriate driving licence for larger buses by 28th August.
Person responsible - PIC

Proposed Timescale: 25/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A photograph was available of the advocate alongside information on advocacy. The name of the advocate was not on the photograph. Some staff on some units were unable to identify the advocate to the inspector on the notice board.

12. Action Required:
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

Please state the actions you have taken or are planning to take:
The service will ensure that each resident has access to advocacy services and information about their rights. This will be achieved by providing information sessions to all staff in relation to advocacy services so that they can facilitate the residents understanding of why and how to access an advocate.

The photograph and details of the NAS Advocate nominee will be displayed in all units. Pictorial and any other relevant augmentative communication system will be utilised to display a charter of resident's rights.

To facilitate all key stakeholders consulted and supported to participate this outcome action will require a lead in time to ensure a meaningful engagement with residents determines what needs to be done to assure them their rights are central to this action. Person responsible - PIC

Proposed Timescale: 30/09/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of the contracts of care is required to ensure both parties have signed each copy. In the sample reviewed, one was not signed by the resident's next of kin.

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

Please state the actions you have taken or are planning to take:
• A full review of the contracts of care will be undertaken. The service will agree in writing with each residents or their representative where the resident is not capable of giving consent, the terms on which the Service User shall reside in the designated centre. To facilitate the achievement of this outcome a full review of all residents contracts will commence as of 1st September with an end date of 30th November Person responsible - PIC

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The detail of any service that may incur an extra cost was not outlined the contract of care for example hairdressing and chiropody. Some residents pay additional charges for reflexology treatments and massage therapies this is not identified within the contract.

14. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
•The service will ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for each Service User and where appropriate the fees to be charged. All costs will be outlined in the contract of care and the services for which the Service Users will incur costs will be clearly outlined.
Person responsible - PIC

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were two admissions to the centre since October 2014. Both admissions occurred as there are no community facilitates or resources for family emergencies or to meet crisis needs.

The most recent resident admitted has required a significant amount of one to one care which has had an impact on the lives of the residents currently accommodated in the unit due to limited staff resources.

15. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
•Local management decision in accordance with the National Congregated Settings Policy as of 1st August 2015 this designated centre will not receive or accept any further admissions onto this campus site.
Person responsible - PIC

Proposed Timescale: 30/09/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was difficult to establish when goals were initially set as only a review date was identified. The objectives of some of the goals of personal plans are very limited and

not linked appropriately to aspirations. Goals referred to one off activities, or everyday activities of living, rather than developmental goals. Where goals were identified individual staff members were not named to take forward objectives in the plan within agreed time scales. The progress being made in achieving goals or the reason why goals were not reached was not documented. No support plans were outlined to help residents achieve their goals.

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

Please state the actions you have taken or are planning to take:
Personal goals are currently being reviewed and will be clearly written with initial and review date.
Personal goals will have an evidence base and rationale for their selection.
Personal goals will be developmental and will include the aspirations of each individual.
Each resident has a named key worker responsible for ensuring that the personal goals are specific/measurable/achievable/relevant and time framed.
Each goal will have a support plan in place.
Achievements or blocks to achieving goals will be documented.
All goals are reviewed on a ongoing basis and within specific agreed timeframes.

The service will ensure that personal plan reviews assess the effectiveness of each plan through audit and take into account changes in circumstances. An audit of PCP's will continue and recommendations will be implemented.

Local team leaders will coordinate this action and will carry out a review commencing 1st August to conclude no later that 11th September 2015.
Person responsible - PIC

Proposed Timescale: 11/09/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Only in a very small number of personal plans were photos available showing residents engaging in their identified goals. There was no use of assistive technology, aids or appliance for example, digital photo frames to promote residents full capabilities in their personal care plan or assisting to communicate their aspirations.

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

Please state the actions you have taken or are planning to take:
The service will ensure that resident's personal plans are made available in an accessible format to the residents and, where appropriate their representatives. This will be achieved through ongoing monitoring of PCP by local team leaders.

Photos and other types of multi-media will be used to show residents engaging in goals

Assistive technology and other aids will be included where appropriate to assist residents to communicate their aspirations.
Person responsible - PIC

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors identified a small number of personal plans were not reviewed within the annual time frame.

18. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
The service will ensure that Service Users personal plans will reviewed annually and more frequently at team leader level. To assist this requirement an audit tool will be developed that will track and trace each review as they occur. Any changes in need or circumstances will be inputted as necessary.
Person responsible - PIC

Proposed Timescale: 31/10/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of the designated centre does not meet the individual and collective needs of all residents in a comfortable and homely way. The building is institutional in style and despite some modifications retains a number of dormitory like aspects of living which detract from person centred care.

The communal areas in some units were not located close to resident's bedroom accommodation and they did not have the option to return to their bedrooms during the day. Some residents did not have good access to their bedrooms during the day.

Some bathroom facilities contained either two or three wash hand basins or two or more toilets enclosed with a cubicle.

The layout and configuration of some units in the main three storey building does not facilitate choice and meet residents' needs.

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

Please state the actions you have taken or are planning to take:
• A local Implementation group has been set up to progress a time to move on from Congregated Settings 'A Strategy for community inclusion'.
Person responsible – Registered Provider

•Families and representatives from various groups including Sligo/Leitrim County Councils are members of this local Implementation Group.
Person responsible – Registered Provider

•A transition planning group has devised a specific transition plan for Service Users. Service Users and families are consulted and involved in this process.
Person responsible – PIC

•It is envisaged that Service Users will be re-located into the community over a five year period.
Person responsible – PIC

•Submissions have been made to the national group on congregated settings Person responsible – Registered Provider

Proposed Timescale: Ongoing over a 5 year period.

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:
The systems to ensure learning to minimise the risk of repeat occurrence of similar incidents between units is not robust and requires review.

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

Please state the actions you have taken or are planning to take:
• The service will review the Risk Management policy to ensure it includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving the Service Users. This review will be undertaken by the PPPG group.
Person responsible – PIC

• Learning from incidents will be circulated to each area and included in the regular meetings at local level. This will be documented at such meetings and any changes to practices as a result of the learning from incidents clearly documented.
Person responsible - PIC

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The summary of risk form requires review to provide more qualitative information to allow for the identification of trends. Some incidents are described as clinical and it is unclear whether they describe weight loss, pressure wounds, and acute illness. The information does not correlate incidents to readily identify a pattern within a particular unit or issue with an individual resident.

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

Please state the actions you have taken or are planning to take:
• The NIMMS system has been introduced as of 1st August, 2015 and will correlate incidents to readily identify a pattern within a particular unit or an issue with and or for an individual resident. This will assist the centre with assessment, management and ongoing review of risk.
Person responsible - PIC

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The fire action notices were not clearly visible. The print was small and some have been in place and not reviewed since 2004.

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

Please state the actions you have taken or are planning to take:
• The service is in the process of reviewing fire action notices as of 10th August, 2015.
• Reviewed notices will be displayed prominently on corridors and other areas as appropriate.
• The fire action notice will be clearly visible format.
Person responsible - PIC

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The personal emergency evacuation plans require review as they are not all based on learning from residents' response to fire drills.

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

Please state the actions you have taken or are planning to take:
• A schedule of fire drills and evacuations has been drawn by management for implementation in service by mid September. The Personal Emergency Evacuation Plans will be updated and reviewed based on the learning from resident's response to drills and evacuations.
Person responsible - PIC.

Proposed Timescale: 30/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Regular simulated fire drill practices were not taking place.

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

Please state the actions you have taken or are planning to take:
•A schedule of fire drills and evacuations has been drawn up by management to be implemented no later than the 15th September, 2015.
•This process will be repeated as per regulatory requirement.
Person responsible - PIC
This will commence in August 2015

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Only 38% of the nursing staff and 45% of the care assistants had fire safety training within the past 12 months. Some staff have not had training in fire safety for a number of consecutive years.

25. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
The service has made arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm fire points and first aid fire fighting equipment, fire control techniques, and arrangements for the evacuation of Service Users.
Date of Training have been agreed and have commenced
Compliance rate as of July 31st
Staff Nurses 75%
Care Assistants 87%
Admin/ maintenance/drivers 90%
Housekeeping 94%

Person responsible - PIC

Proposed Timescale: 07/08/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The number of days the behavioural support therapist is available has decreased. A number of behavioural support plans were past their annual review date.

26. 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 current review is been undertaken by the Behaviour Therapist of Behaviour Support Plans which will be updated as required.
• The centre will have access to the Behavioural Support Therapist support as and when required as of 17th August 2015

Person responsible - PIC

Proposed Timescale: 01/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training in the management of behaviour that is challenging including de-escalation and intervention techniques had not been provided to all staff.

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

Please state the actions you have taken or are planning to take:
• Training in management of behaviours that challenge and de-escalation and intervention techniques is in place with scheduled dates as follow;
·8,9,10th September'15,
·27,28,29th October'15,
·10,11,12thNovember'15.
·Further dates will be scheduled
Person responsible - PIC

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Work is required to ensure all staff have up to date training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Please state the actions you have taken or are planning to take:
The service will ensure that all staff receives appropriate training in relation to safeguarding residents. This will cover the prevention, detection, and response to all levels of abuse.
Training schedule is in place and commencing 24th August 2015.
Person responsible - PIC

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some intimate care plans were not reviewed annually in the sample of files examined.

29. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
Safeguarding measures are in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the residents Personal Plan and in a manner that respects the resident's bodily integrity and privacy. This outcome will be monitored and audited by local team leader and feedback provided to PIC monthly.

All intimate care plans will and are reviewed annually. Dates of reviews are scheduled each year and invitees will be included as per residents support needs.

For the purpose of this outcome an audit will be completed to assure that this practice is verified, attainable and recorded within the residents PCP. Audit will complete on this outcome no later than 30th September.
Person responsible - PIC

Proposed Timescale: 30/09/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Further investment is required to expand the level and frequency of service to residents taking account of residents' ability and life stage. Some residents continue to lead a very passive lifestyle and there were limited options for meaningful engagement throughout their day.

30. Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
Sonas training is scheduled to commence on the 4th September due to complete on 6th November. The purpose of this training is to update staff with specific skills to support residents to access opportunities for education, training and to facilitate community participation.

The range of activities provided in the Board Walk Day Service has been expanded in line with the community networking needs of the Service Users attending since 6th July 2015.
Person responsible - PIC

Proposed Timescale: 04/09/2015

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:
Three monthly evaluations of nursing care plans as required by the centre's procedures did not always take place. Some care plans to meet a nursing need were not reviewed for an eight month period.

31. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
•The service will ensure that the nursing care plans are reviewed and updated in line with the health care needs of the residents which are underpinned by the designated centres nursing practice PPPG's.
Person responsible - PIC

Proposed Timescale: 31/07/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The medication management policy was not updated as required by the action plan of the last inspection report. The procedure for ordering medication in practice was not reflective of the policy.

32. Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
The service will put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely. This will be

monitored and reviewed by the medication management team of the designated.

The medication management policy will be updated to include process for ordering of medication.
Person responsible - PIC.

Proposed Timescale: 31/08/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An assessment was undertaken to ascertain if a resident had the capacity to manage their own medication safely. However, the assessments require review as they were not revised in some cases for a significant timeframe.

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

Please state the actions you have taken or are planning to take:
The service will risk assess ability of individual residents to manager own medication and encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability as appropriate. This assessment will determine any changes needed to ensure this outcome is achieved.

The medication management team will be directed to complete this task in accordance with best practice guidelines.
Person responsible - PIC

Proposed Timescale: 18/09/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The kardex' were not always legible and pose a risk of potential medication error. The specific information was not always detailed in the correct column. In some case new drugs were added to the bottom of the sheet for PRN (as required) medication outside of the columns.

34. 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:
Meetings are requested with prescribers in as timely a manner as possible. To this end letters of request are being issued [as of Monday 17th August] in relation to the completion of Kardex in a legible manner. The target date for completion of this outcome component is 30th September.

Medication audit schedule will be developed to ensure compliance in conjunction with pharmacist, GP, Psychiatrist MHID Team.
Person responsible - PIC

Proposed Timescale: 30/09/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
This inspection identified very visible gaps in the quality of life provided to residents. There was no real change in practice or evidence of progress to implement change since the inspection in October 2014.

There was a significantly poor level of compliance with mandatory training requirements.

There was no constructive supervision by management to respond to the poor attendance at training organised.

There was inconsistency and variation in the standard of care practices across all units visited.

Practice in physical care interventions by staff between units varied.

A review of the staff rostering arrangements was not undertaken to ensure resources are allocated to where the need is most required.

35. 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:
Mandatory Fire Training has increased up to a 85% rate for total staff
Managements and governance systems in place in the designated centre. These governance systems include; structured team meetings with clear goals to support the rights and dignity of all resident; quality improvement walk rounds which requires the team leaders to note/record observations and to provide on the ground supervision to frontline staff; conduct a review of incident/accident logs to determine any trends of concern;

A Governance Supervision framework has been introduced since 3rd August with all management grades. The purpose of this framework is to guide and enhance better support for all staff.
This will include;
o Monthly Performance Monitoring report.
o Quarterly operational plan update.
o Quality improvement plan.
o HIQA notifications.
o Incident Notifications.
o HIQA Action Plan.
o Medical Safety Alerts.
o Complaints & Risk Management.
o Absenteeism.
o Budget Control Reports
o HR Memos and other relevant directives.
o IR Matters.
o Congregated settings (LIG)
o Steering oversight committee for dementia.
o Housing.
Person responsible PIC

A schedule of mandatory training has commenced since 1st July. Team leaders will monitor and ensure attendance at mandatory training.

The centre workforce allocation will be assessed to reflect a skill mix ratio to facilitate resident's experiences of consistency with the purpose of enabling the promotion of the delivery of a safe quality care service. This assessment will include an audit tool to capture the real experiences of the resident living in this designated centre. This audit tool will inform any necessary changes required to address any gaps in practice.
Person responsible - PIC

Proposed Timescale: 14/09/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Investment is required to enhance the physical aspects of the unit being developed as a day service and to expand the level and frequency of service to residents taking account of residents' ability and life stage. There was a limited equipment and craft material available to ensure adequate resources for meaningful engagement.

36. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The physical aspects of the Day Service referred to as the Board Walk Service is being enhanced: Internal painting of this facility commence 1st August due to complete 30th September. Resources will be made available as of 24th August to purchase any necessary material/equipment to enhance the experience for the residents attending. Appropriate and relevant equipment is currently being sourced.
Person responsible - PIC

Proposed Timescale: 30/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The deployment of nursing and care staff in terms of where the need is most required is not adequate. The rationale underpinning the staff deployment model is not apparent.

A review of the staff rostering arrangements was not undertaken to ensure resources are allocated to where the need is most required.

There was an insufficient bank of nursing and care staff available to adequately meet resident's needs and ensure continuity of care.

37. 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:
A centre workforce skill mix allocation assessment will be conducted by the team leaders from the residents PCP perspective to reflect a user friendly ratio to facilitate resident's experiences of consistency.

The service is awaiting the appointment of additional staff of 2 staff nurses and 3 care assistants which has been approved. Currently HR is processing these additional posts. As previously identified under outcome 14 we are proposing to complete a workforce review against the profile of the residents needs with the purpose of a more efficient utilisation of resources at frontline across the 24 hour period. The anticipated outcome should enhance the residents experience in accessing opportunities to participate in the community or achieve personal goals in accordance with their preferences. This review is at the beginning of a consultative stage with all relevant stakeholders e.g. residents, advocates and staff. This review will be completed by 30th November 2015 with anticipated roll out. Person responsible - PIC

Proposed Timescale: 30/11/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care assistant staff were not trained in the administration of emergency medication in the event of a seizure by a resident.

All staff did not have refresher training in safe moving and handling of residents as their current certificate of training had expired. Records reviewed indicated only 43% of nurses and 29% of care assistants had up to date training.

Training in activities was identified by the inspector as a requirement to support the staff leading the service to ensure opportunities to participate in activities in accordance with their interests, capacities and developmental needs.

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

Please state the actions you have taken or are planning to take:
Training in the administration of emergency medication required in the event of a service user having a seizure has been requested [SAMs Training] and will commence by the 15th September 2015;

Training in safe moving and handling is ongoing. 8 staff completed this training on August 11th 2015;;

The Sonas training for staff is scheduled for September as referred to previously. This will provide staff with skills to support residents to participate in activities in accordance with their interests, capacities and developmental needs.
Person responsible - PIC

Ongoing action with review date identified for 28th August and every calendar month there after.

Proposed Timescale: 28/08/2015