

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	No.2 Stonecrop
<b>Centre ID:</b>	OSV-0002277
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Southern Services
<b>Provider Nominee:</b>	Una Nagle
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Kieran Murphy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	4
<b>Number of vacancies on the date of inspection:</b>	1

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

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

From:	To:
07 February 2017 08:00	07 February 2017 16:30
08 February 2017 08:30	08 February 2017 16:30

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

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

**Summary of findings from this inspection**

Background to the inspection:

This was the second inspection of this centre. The first inspection took place on 10 June 2014. This inspection was scheduled in response to an application of the provider to register this inspection.

This inspection was also informed by information received from the provider in the days prior to this inspection. The provider submitted the summary recommendations of a systems analysis investigation, which had been completed on April 8th 2016 but not submitted to HIQA until Monday 6th February 2017. The systems analysis

investigation had been commissioned by the provider on foot of two allegations, neither of which had been notified to HIQA as required.

The systems analysis investigation considered the contents of:

- a protected disclosure regarding five alleged incidents of challenging behaviour (of a specific nature) on specified dates in 2014 and 2015 and another similar incident on a specified date that pre-dates the commencement of the regulations
- a note to the file of the Chief Officer of the relevant community health organisation in the HSE (Health Service Executive) concerning one of the aforementioned alleged incidents in May 2015
- a report from the HSE confidential recipient, again concerning one of the aforementioned alleged incidents in May 2015.

At this inspection, inspectors followed up on progress against the 16 recommendations contained in that report (one of which is not applicable to this designated centre).

How we gather our evidence:

Inspectors met with the four residents living in the centre over the course of the inspection.

Inspectors spoke with the person in charge, social care leader and members of the staff team about their understanding of individual resident's key support requirements and how they supported residents to meet those requirements. Inspectors also reviewed documentation such as personal plans, healthcare records, information pertaining to restrictive practices, meeting minutes and training records.

Description of the service:

The centre could accommodate five residents and at the time of inspection provided a home to four residents. The centre is a bungalow located in a community setting in a suburb of a city.

Residents communicated to inspectors how they made choices, what they liked to do during the day and the people important in their lives. Staff demonstrated that they knew residents well and staff were observed to support residents to make decisions, to communicate and to be as independent as possible. Interactions between staff and residents were comfortable and appropriate.

As part of the Brothers of Charity annual review in 2016 of quality of life and safety of residents in this centre, the service had identified that more suitable accommodation was required for the residents currently living there. The premises itself was warm and pleasantly decorated. Some residents chose to show inspectors their rooms, which they had personalized.

Overall findings:

The provider demonstrated that they were progressing the recommendations contained in the report of the systems analysis investigation to ensure the organisation would adhere to policies on the reporting and management of concerns related to sexual and physical abuse. Progress reviewed indicated the provider would

appropriately respond to any safeguarding concerns, would implement in full safeguarding protection plans and ensure that there were satisfactory communication pathways in place going forward.

However, four major non-compliances were identified at this inspection:

- the location, design and layout of the centre did not meet residents' needs as it was not accessible for the residents living in the centre, which was contributing to the risk of residents falling (outcome 6)
- key risks were not included on the risk register (outcome 7)
- it was not demonstrated that adequate supports were provided for residents with behavior support needs and a safeguarding plan had not been implemented in full (outcome 8)
- the provider had failed to notify HIQA about allegations of abuse and failed to provide updates to HIQA in relation to those allegations (outcome 9).

Other improvements were required in relation to oversight of the centre, healthcare plans, staff training and residents' rights.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met can be found in an action plan at the end of this report.

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

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

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Overall, arrangements were in place to consult with residents and to protect their dignity. Improvements were required to ensure that residents' rights were being satisfactorily protected.

Inspectors reviewed the complaints log. There was process to ensure that complaints were resolved and most of the complaints had been resolved satisfactorily. However, two complaints were ongoing, with the first relating to the environment not being suitable for all residents and in particular that one resident's freedom of movement within the house was being restricted. These issues will be further discussed under outcomes 6 and 8.

The second complaint related to the use of a resident's car by other residents. The person in charge confirmed that the car was the property of one resident but the Brothers of Charity service paid the cost of insuring, taxing and servicing of the car and that it was used by other residents. However, inspectors were not provided with any agreement or evidence of consultation that clearly outlined the agreed and appropriate use of this vehicle.

Where a ward of court arrangement was in place, there was inadequate documentation relating to the extent of the wardship. Staff did clearly articulate though their understanding of the arrangement.

Residents were consulted with and participated in decisions about their care and the organisation of the centre. There were weekly meetings with residents and issues

discussed included activities, any issues, and sessions on personal safety and the use of assistive technology.

Residents were supported to keep control of their own possessions. There was an up to date property list in each resident's personal outcomes folder which identified when the resident bought or received items like furniture or bedside lamps. There was adequate space for clothes and personal possessions in all bedrooms.

**Judgment:**

Non Compliant - Moderate

**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Overall, there were arrangements in place to support residents' communication needs.

There was a policy in place relating to communication. An assessment of each individual's sensory needs, including vision, mobility and hearing had been completed. Involvement of other professionals, such as speech and language therapy, audiology or the national council for the blind had been sought where required.

Residents' preferred means of communication was reflected in residents' personal plans, including the use of any aids or technologies.

Staff were observed to support residents to communicate, in line with their communication care plans and residents' independence to express their choices, emotions or wishes was supported using a variety of means, including pictures, individualized dictionaries, aids and technologies.

**Judgment:**

Compliant

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

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

<p><b>Theme:</b> Individualised Supports and Care</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> Overall, family relationships, friendships and links with the community were supported.</p> <p>The statement of purpose outlined that family members and friends were encouraged to visit and made feel welcome. Residents were supported to visit family members and to stay overnight if they wished to do so. Relationships were encouraged and re-established. Residents showed inspectors photographs and albums of friends and family members that decorated their rooms.</p> <p>Transition planning considered the key importance of maintaining family links and friendships. Transition planning also invited participation of residents' representatives as appropriate.</p> <p>The centre was located in an established part of a city. Residents participated in activities in the community, in accordance with their wishes and needs both as part of their day service and in the evenings and at weekends. This included going to the cinema, going recycling, meeting old friends, visiting the nearby kitchen campus and going for a walk. Day trips and holidays were also enjoyed.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b>Outcome 04: Admissions and Contract for the Provision of Services</b> <i>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.</i></p>
<p><b>Theme:</b> Effective Services</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> Overall, while written contracts of care were in place, the processes in place that related to the transfer of residents required review.</p> <p>At the previous inspection, written contracts of care were not in place. Inspectors saw examples of written contracts of care at this inspection.</p>



There had been no admissions to the centre since commencement of the regulations. The organisation had policies and procedures in place in relation to such admissions and an admissions and transfers committee was in place to oversee any such admissions.

**Judgment:**  
Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**  
Effective Services

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

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

**Findings:**

Overall, residents' personal plans were individualized. However, improvements were required in relation to the part of the personal plan that pertained to residents' healthcare needs and ensuring their full participation in the review of their own plan. Also, further evidence was required in relation to ensuring that discharges from the designated centre would take place in accordance with the resident's assessed needs and their personal plan.

Templates were in place for the assessment of each resident's health, personal and social care support requirements. There was a comprehensive assessment of each resident's personal and social care support requirements, including communication skills, daily living skills, money skills, social functioning, personal safety and cognitive skills. However, some improvements were required. While the assessment of residents' personal and social care support requirements was comprehensive, the assessment of each resident's healthcare needs was not.

There was also a personal planning process in place that involved information gathering with respect to each resident's personal goals and tracking to ensure that those goals would be achieved. Residents' personal plans overall were comprehensive with consideration given to key aspects of residents' lives, their work, relationships, living arrangements and what was important to each individual.

A booklet was available for staff to record relevant and important information in the

event of a resident being transferred to hospital, including any communication supports and any support required during mealtimes or to take medication.

However, while there was evidence of residents' participation in the development and annual review of their personal plan, residents' participation in the quarterly review of how their plan was progressing was not demonstrated, despite the form clearly indicating that their participation was required.

Where transfers were planned, a multi-disciplinary review had taken place that considered the familiarity of the suggested area, activities enjoyed, maintaining friendships and continuity of residents' day service. Where potentially suitable premises had been identified, an occupational therapy assessment had been completed as part of the transition process to ensure any mobility supports would be provided in the new house.

However, where the multi-disciplinary team raised reservations about a suggested alternative campus-based placement and identified it as the least desirable option, it was not clear whether more suitable alternatives would continue to be explored.

The resident's personal plan highlighted the importance of a community-based placement to them. It was noted that a meeting was scheduled with resident's representatives to discuss the proposed placement further.

**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):**

No actions were required from the previous inspection.

**Findings:**

Overall, the location, design and layout of the centre did not meet residents' needs as it was not accessible for all. Obvious hazards seen by the inspectors included a steep driveway, a narrow porch entrance with steps, a number of trip hazards in the house itself and an inaccessible bath.

The centre provided a home to four residents and was based in a community setting in a suburb of a city. As part of the Brothers of Charity annual review in 2016 of quality of

life and safety of residents in this centre, the service had identified that "more suitable accommodation" was required for the residents currently living there.

The centre was set on a busy main road with access being up a steep driveway. Most residents living in this house had a mobility impairment with some high needs. Inspectors observed residents receiving assistance to walk down the driveway as transport could not easily get up and down the steep slope.

The entrance to the house was via a porch that had steps leading to the main door. The service had commissioned a report in 2016 from a qualified moving and handling instructor. This report had outlined that the porch could not be adapted to provide for greater accessibility. In addition, this report had outlined that the bath in the main bathroom, while it had an electric seat to move up and down, was not accessible for all residents.

Inspectors had viewed the incident reporting system from January 2016 to February 2017 and noted that there was one recorded fall by a resident on the steps of the house. There were also four recorded falls by residents tripping over door saddles between different rooms in the house, two falls getting out of the bath and a fall on the bathroom floor.

The house was nicely decorated and had a fully fitted kitchen, a separate dining room and a sitting room with a television. There were pictures of the residents hanging throughout the house and this made for a very homely feel. Each resident had their own bedroom, which some residents chose to show inspectors. Those bedrooms were individualised and comfortable with personal effects and items.

There were two bathrooms, one of which had a bath, toilet and wash hand basin. The second bathroom had an accessible shower area. There was a patio area to the back of the house with a rear garden. One resident showed inspectors where he liked to relax in the back garden.

**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):**

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

**Findings:**

Overall, the arrangements in place for assessing and controlling risks were not

adequate.

There was a risk management policy that included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm.

Each resident had participated in identifying specific hazards relating to their lives, for example in relation to road safety and these risks were included on the risk register. However, key risks were not included on the risk register, including active safeguarding risks as a result of challenging behaviour and the risk of injury due to the inaccessibility of the premises.

Where there was a risk associated with inappropriate behaviour or utterances, it was not demonstrated that the risk assessment had been developed with input from relevant healthcare professionals. As it was not demonstrated that the control measures in place were proportionate to the level of risk. This potentially had an impact on residents' quality of life.

There were three separate recording systems for incidents, one form for incidents of challenging behaviour, one form for recording of accidents or incidents and a third form for recording medicines management incidents. Inspectors reviewed the incident reporting systems from January 2016 to February 2017, which recorded 27 resident falls.

Where residents were at risk of falls, a specific falls risk assessment had taken place and there were separate analysis forms for resident falls to identify trends in the types of falls that had occurred. It was demonstrated that there was on-going multi-factorial exploration of the cause of any falls and regular review by residents' general practitioner (GP) in relation to any falls.

Staff outlined a process whereby a hoist was available if a resident had a fall and was unable to assist themselves from the floor. However, not all staff had received training or instruction in relation to the use of the hoist or how to support residents who had fallen. This will be addressed under outcome 17.

The person in charge and director of service outlined a new system that had been introduced whereby if there were accumulated incidents relating to behaviours that may challenge, there were escalation protocols in place to notify the designated liaison person. This new escalation protocol had been introduced to ensure that potential safeguarding issues for residents were reviewed by the designated liaison person.

During this inspection the main fire safety installations of fire alarm panel, emergency lighting and fire extinguishers were all within their statutory inspection schedules with all relevant certificates available on site. There were fire doors installed throughout the house and there was emergency signage identifying escape routes.

It was not demonstrated what plan was in place to evacuate residents in the event of a fire and bring them to safe locations, should a fire start when residents were asleep.

Training records indicated that all staff had been trained in fire safety management,

food safety and infection control.

There was a policy and procedures in place with respect to the prevention and control of infection. Staff articulated an understanding of what to do in the event of an outbreak of an infectious disease. Hand hygiene equipment was available and personal protective equipment, if required.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

Overall, adequate measures were not in place to safeguard residents from harm as a safeguarding plan in place had not been implemented by the proposed date. At the time of this inspection, the provider was progressing recommendations to address systems failings identified in an investigation report that related to the management of safeguarding concerns.

At this inspection, inspectors followed up on progress against the recommendations contained in a systems analysis investigation report completed on April 8th 2016, which was not submitted to HIQA until Monday 6th February 2017. The report contained 16 recommendations to ensure that the organisation would adhere to policies on the reporting and management of concerns related to sexual and physical abuse, would appropriately respond to any safeguarding concerns, would implement in full safeguarding protection plans and ensure that there were satisfactory communication pathways in place. One recommendation was not applicable to this designated centre.

Overall, the provider demonstrated that they were working to progress the report recommendations. For example, a designated person now worked full-time in the service and systems were being developed and implemented in relation to staff supervision, training, communication, reporting of incidents and concerns, prioritization of transfer placements where safeguarding concerns exist and oversight of the management of and

response to safeguarding concerns.

However, further improvement was required as gaps were identified in relation to fully implementing a safeguarding plan in place that related to transfer placements. Also, a completed action plan that more clearly tracked the progress against each recommendation was required.

Where there was challenging behaviour between residents, supports had been put in place. Supports included input from a behaviour support specialist, a recent psychology assessment, a safeguarding plan was being followed by staff, a behaviour support plan was in place and a communication protocol was also being implemented by staff.

However, the safeguarding plan had not been fully implemented by the timeline proposed in a notification to HIQA of the end of December 2016 and a revised timeline could not be confirmed at the time of this inspection. In the interim, residents were being kept apart from each other. However, this was not a sustainable situation due to the limitations of the design and layout of the house and the impact on residents in that they could not freely move about their own house.

While some residents with behaviours that may challenge had access to behaviour support and/or psychology support, other residents did not, despite a clear need having been identified and repeated referrals made.

Residents had been supported to develop knowledge and skills in relation to self-care and protection and where appropriate, training in relation to relationships and sexuality had been provided to residents.

At the previous inspection, gaps were identified in relation to staff training. At this inspection, staff had received training in relation to the protection of vulnerable adults. However, some staff had not received training in relation to positive behaviour support.

**Judgment:**

Non Compliant - Major

**Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

Significant failings were identified in relation to the statutory requirements to notify

incidents to HIQA or to provide updates in relation to the management of any allegation, suspicion or incident of abuse against residents.

A notification had not been made with respect to a report from the HSE (Health Service Executive) confidential recipient concerning three specific alleged incidents of challenging behaviour (of a specific nature) in May and August 2015.

A notification had not been made with respect to a disclosure made to the authorised person of the HSE under Protected Disclosures of Information on 10 August 2015. The disclosure related to five alleged incidents of a similar nature on specified dates in 2014 and 2015 and a further similar incident on a specified date that pre-dates the commencement of the regulations (in 2012). The allegation was that of failure of the provider to protect residents from harm as a result of this behaviour.

In accordance with HIQA guidance on notifications, the provider had not ensured that the person in charge provided updates to HIQA with respect to how any allegation, suspicion or incident of abuse was being managed and specifically, that the provider had commissioned a systems analysis investigation on 28 July 2015.

Also and in accordance with the HIQA guidance on notifications, the provider had not submitted the systems analysis investigation report as soon as it was available. The report of the systems analysis investigation was completed on April 8th 2016 but was not submitted to HIQA until Monday 6th February 2017.

The provider committed to completing retrospective notifications in relation to the above alleged incidents. Also, the provider had already commenced a full review of their own internal processes regarding notifications to HIQA to ensure that all notifications would be submitted as required in the future.

**Judgment:**

Non Compliant - Major

**Outcome 10. General Welfare and Development**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

Overall, arrangements were in place to ensure that residents' opportunities for new experiences, social participation, training and skills development were facilitated and

supported.

Residents' skills and personal development goals were assessed as part of the personal planning process. All residents attended a day service and communicated to inspectors that they liked going to the day service. A daily schedule was available for review that reflected a variety of activities and interests. Day service staff attended residents' personal planning meetings to contribute to the part of residents' plans that pertained to skills and personal development.

Inspectors observed that residents' were encouraged to develop and maintain independent living skills, including in relation to day to day tasks such as making tea, tidying up, loading the dishwasher and organising what would be needed for that day. Other key skills were supported, including in relation to using electronic communication apps.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Overall, arrangements were in place to assess and meet residents' healthcare needs.

Residents had access to a GP and out of hour's service. Residents also had access to consultants as required and reports were available from any visits, which informed the support provided. Access to some allied health professionals including speech and language therapy and occupational therapy had been arranged where required.

In addition, there was evidence of a multi-disciplinary approach to the management of falls involving medical and allied health professionals.

The system for tracking referrals was not clear and it was not demonstrated that staff were following the organisation's referral process, which included a mechanism for flagging any delays. This was being addressed at organisational level at the time of inspection by the multi-disciplinary team.

Improvements were required to the part of residents plans that related to healthcare. Information relating to key support needs was contradictory in different places. For



example, information in the hospital booklet, review meetings and healthcare assessment template was not consistent. Healthcare plans did not clearly direct the care and support to be given. In practice, inspectors did not find any gaps in relation to meeting residents' healthcare needs and staff clearly articulated each resident's healthcare needs and the supports in place.

Residents' choice in relation to meal planning was facilitated through weekly resident meetings. Residents alternated which day that they chose the menu for that evening. Menu options were visibly displayed in pictorial format on a menu board in the kitchen and inspectors saw that residents also used assistive technology to choose what they wished to eat for breakfast.

Where residents required a special diet, input from the speech and language therapist had been provided and written guidance was available. Inspectors observed that the guidance was implemented in practice.

A separate kitchen and dining room was provided, although residents preferred to have their meals in the smaller but cosier kitchen.

**Judgment:**

Substantially Compliant

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

Overall, there were policies and procedures in place in relation to medication management.

There was an organisational medicines management policy in place and a local procedure had been developed since the previous inspection. Staff demonstrated an understanding of the principles of safe medication management and adherence to guidelines and regulatory requirements. Keys were kept securely.

Measures were in place for the secure storage of medicines. Medicines were ordered on a monthly basis and a log of any orders was maintained. A stock taking system had been introduced recently to the centre.

Where any PRN ("as required") medicines were used, an individual protocol signed by

the resident's psychiatrist was in place. Staff demonstrated an understanding of how and when to follow the protocol. The administration of PRN medicines was monitored by the general practitioner and/or psychiatrist, as appropriate. Psychotropic medicines were counted each night by two staff members.

Medication prescription and administration records were maintained in accordance with relevant legislation. Staff demonstrated an understanding of how to manage any changes to the prescription, such as the need to withhold a medicine. Medication administration records identified the medicines on the prescription and allowed space to record comments on withholding or refusing medications. Where medicines were administered in the day service, a record of the transfer of those medicines to day service staff was maintained. A record of any vaccinations received was also maintained.

Medicines which were out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A record of the return to pharmacy was maintained.

A recent medication audit had been completed in the centre by the person in charge and an action plan to track any required actions. Any medication errors were recorded on an incident form and reviewed by the person in charge.

The training matrix confirmed that all staff identified to work in the centre had received training in medicines management and epilepsy awareness (including the administration of any rescue medication).

**Judgment:**

Compliant

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

**Findings:**

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

However, inspectors found that improvements were required. The statement of purpose did not meet the requirements of schedule 1 of the regulations nor did it accurately reflected the premises and satisfactorily outline what services would be provided to residents. For example, the statement of purpose submitted to HIQA was dated 2015.

The statement of purpose reviewed in the centre was dated 2017 but also required improved as it did not:

- accurately reflect the persons participating in the management of the service
- accurately reflect the premises
- provide sufficient information regarding admissions to the centre and whether emergency admissions were accepted
- outline how residents would be provided with access to the services of allied health professionals in a satisfactory way and based on need.

**Judgment:**

Non Compliant - Moderate

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Overall, the provider had been working to strengthen the governance system in this centre. Further improvement was required to the monitoring of quality and safety of care and to feedback mechanisms in the event of a concern having being raised.

There was a clear management structure in place. A social care leader worked full-time in the centre and reported to the person in charge. The person in charge reported to the sector manager, who in turn reported to the representative of the provider.

The person in charge met the requirements of the regulations in terms of experience, qualification and skills. The person in charge was also in charge of six other centres and visited the centre fortnightly. In between visits, the person in charge was in contact with the social care leader over the phone.

An inspector reviewed reports of unannounced biannual visits that had been completed

by the provider. However, it was not demonstrated that these visits adequately reviewed the safety and quality of care and support provided in the centre.

For example, the report did not address previous concerns about the recording and reporting of incidents and it did not identify that a resident required a behaviour support plan. It also did not reference the restricted movement of residents in the house. The premises were not considered as part of the visit, despite the health and safety concerns related to the physical premises. Also, on-going peer to peer challenging behaviour was not considered as part of the visit.

The report for the annual review for the previous year was reviewed and also required improvement to ensure that it adequately reviewed the safety and quality of care and support in the centre and assessed whether such care was in accordance with standards.

For example, the annual review stated that residents have a behaviour support plan where required but this was not found to be the case on this inspection. The review did identify other key issues such as the suitability of the premises, the ageing profile of residents and incompatibility of residents. The plan to address these issues was not clearly outlined in the annual review.

The system for ensuring that staff could raise concerns about the quality and safety of care being provided in the centre was being developed on foot of the report of the systems analysis investigation discussed under outcome 8. Further clarity was required to provide reassurance in relation to how staff would be facilitated to raise concerns and how feedback would be received (e.g. from the multi-disciplinary team) in the event of any concern having being raised.

**Judgment:**

Non Compliant - Moderate

**Outcome 15: Absence of the person in charge**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

The provider was aware of the obligation to submit a notification in the event of any proposed absence of the person in charge and the arrangements to cover for the absence.

There were adequate arrangements in place for the management of the centre when the person in charge is absent. A person participating in the management of the centre (the sector manager) was identified to deputise for the person in charge in the event of an absence exceeding 28 days.

**Judgment:**

Compliant

**Outcome 16: Use of Resources**

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**

Use of Resources

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

No actions were required from the previous inspection.

**Findings:**

Overall, the use of resources had been assessed and identified to ensure the effective running of this centre.

There was a system in place for the identification of any maintenance issues or equipment requiring replacement on an emergency basis.

The centre was in clean and in a good state of repair both internally and externally.

**Judgment:**

Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

Overall, staff levels were appropriate to meet residents' needs at the time of inspection.

Staff demonstrated that they knew residents well and staff were observed to support residents to make choices, express how they felt, to communication and to be as independent as possible. Interactions between staff and residents were comfortable and appropriate.

At the previous inspection, staff files were not complete and mandatory training was not up to date. Since the previous inspection, staff had received further training in relation to safeguarding and training in relation to supporting relationships and sexuality. At this inspection, some gaps were identified in the training records that related to mandatory training and other training required to support residents' needs.

This included training in relation to manual handling and training or instruction in relation to the use of the hoist or supporting residents who had fallen, training in relation to hand hygiene, infection control, risk assessment, food safety, personal planning and supporting residents with dysphagia.

Staff team meetings were held regularly and staff said that they could add items to the agenda as necessary. Staff appraisal systems were in place. The person in charge and social care leader had received training in relation to staff supervision and this process was soon to commence. An induction folder was available for new staff, which provided a clear picture of the key things to know about each individual and how to support their individual needs.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

**Findings:**

Overall, records and documentation were stored securely and made available for review. Improvement was required to the policy on protection of vulnerable adults.

Records were kept securely in a locked office and confidential files stored securely and made available to inspectors for review where required.

Residents' records as required under Schedule 3 of the regulations were maintained. Records listed in Schedule 4 to be kept in a designated centre were also made available to inspectors.

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

All the required policies and procedures as required under Schedule 5 were made available to the inspectors. Staff with whom the inspectors spoke demonstrated an understanding of specific policies such as the medication policy and the complaints policy. Easy-read versions of policies were also prominently displayed in the centre.

However, the policy to inform the protection of vulnerable adults did not sufficiently outline the regulatory reporting procedures to be followed in the event of an allegation, suspicion or incident of abuse.

A directory of residents was maintained in the centre and was made available to the inspector.

There was a policy on the provision of information to residents and a residents' guide was available which included:

- a summary of the services and facilities provided
- the terms and conditions relating to residency
- arrangements for resident involvement in the running of the centre
- how to access previous inspection reports
- complaints procedure
- arrangements for visits.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Julie Hennessy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority



## Health Information and Quality Authority Regulation Directorate

### Action Plan



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

<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
<b>Centre ID:</b>	OSV-0002277
<b>Date of Inspection:</b>	07 and 08 February 2017
<b>Date of response:</b>	16 March 2017

### 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:**

Where a ward of court arrangement was in place, there was inadequate documentation relating to the extent of the wardship.

**1. Action Required:**

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise

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

his or her civil, political and legal rights.

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

1. The Services has established an Oversight Committee to monitor the local management of the affairs of residents who are Wards of Court.
2. The Person in Charge will ensure that the necessary documentation in relation to the wardship is available at the Centre and staff are clear on the issues that require sanction of the local Committee members and on the issues that require sanction of the Wardship Office including its Medical Officer.
3. The Person in Charge is working with the local Ward Committee member in relation to the Personal Plan of the resident in the Centre who is a Ward of Court.

**Proposed Timescale:** 30/04/2017

**Theme:** Individualised Supports and Care

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

A written agreement was not available that clearly outlined the agreed and appropriate use of a resident's personal property.

**2. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

The Person in Charge will seek written clarification from the Wardship as to the agreed and appropriate use of a resident's personal property.

The Person in Charge will then put a written agreement in place between the Resident and the Services in this regard.

**Proposed Timescale:** 30/04/2017

**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:**

Residents' participation in the quarterly review of how their plan was progressing was not demonstrated, despite the form clearly indicating that their participation was required.

**3. Action Required:**

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and

where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

The Person in Charge will ensure that in future, the maximum participation of each Service User at each of their quarterly reviews is fully evidenced

**Proposed Timescale:** 30/04/2017

**Theme:** Effective Services

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

The assessment of each resident's healthcare needs was not comprehensive.

**4. Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

1. The procedures for the assessment of the residents' health care needs will be reviewed to ensure that it is comprehensive in identifying all of the relevant healthcare issues to inform the Personal Plans of residents.
2. The current full assessment of the residents support needs, including the relevant multidisciplinary inputs which commenced as part of an ADT process given the changing needs of residents in 2016 will be completed for all residents by 30 April 2017. The updated healthcare assessments will form part of this review and the relevant healthcare personnel will be consulted with as part of the process.

**Proposed Timescale:** 30/04/2017

**Theme:** Effective Services

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

It was not fully evidenced that discharges from the designated centre would take place in accordance with the resident's assessed needs and the resident's personal plan.

**5. Action Required:**

Under Regulation 25 (4) (c) you are required to: Discharge residents from the designated centre in accordance with the resident's assessed needs and the resident's personal plans.

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

Evidence of the Admissions Discharges and Transfer (ADT) Process for inappropriate

placements is now available in the Centre [27 February 2017].

2. One resident has had a full multidisciplinary review completed as part of the ADT Process in February 2017 and was recommended to transfer to another Centre. It is planned that this transfer will take place in April 2017.

3. A second resident was referred to ADT in October but a possible alternative placement was not identified until February. The ADT Process will be reactivated as follows:-

(a) The family relative/Ward of Court Committee members to be invited to visit the proposed alternative centre

(b) Local Multidisciplinary Team members and Medical Officer in Wardship Office will be invited to input into the ADT process

(c) If there are no major issues from a & b above the resident will be facilitated to visit the centre and his views will be sought

(d) The ADT Committee will be asked to recommend on this proposed placement by 30 April 2017

4. The PIC has commenced the ADT Process for the remaining 2 residents and the ADT Committee will be asked to recommend on this proposed placement by 30 April 2017

5. If ADT approve all transfer the transition plans can commence in May 2017.

6. If the ADT committee does not recommend the proposed transfer then alternative options will be considered with the residents and their circle of support. [31/05/2017]

7. In the event of a discharge/transfer being necessary on the grounds of Health & Safety reasons i.e. where the support needs cannot be met in the Centre, the Provider will ensure that this option will only be taken as a last resort and that all options to maintain the current placement are fully explored until a suitable alternative is available to the resident.

**Proposed Timescale:** 30/06/2017

## **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 location, design and layout of the centre did not meet all residents' assessed needs.

### **6. 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:**

1. All door saddles identified as possible trip hazards have been removed except for one which needs additional building remedy works. This will be complete by 31/03/2017

2. The Facilities Manager and Occupational Therapist will carry out an updated environmental assessment and devise a plan to ensure all internal areas in the centre

are accessible to residents. This plan will be ready to action if the proposed transfers to alternative centres are not approved by 30 April 2017 or are likely to be delayed. If required these works will be completed by 30 June 2017

3. The plan identified at 2 above is regarded as an interim plan to support residents until a suitable alternative location is agreed for all residents.

**Proposed Timescale:** 30/06/2017

**Theme:** Effective Services

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

The centre was not accessible for all residents residing in the centre.

**7. Action Required:**

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

The Facilities Manager and Occupational Therapist will carry out an updated environmental assessment and devise a plan to ensure all internal areas in the centre are accessible to residents. This plan will be ready to action if the proposed transfers to alternative centres are not approved by 30 April 2017 or are likely to be delayed.

**Proposed Timescale:** 30/06/2017

**Theme:** Effective Services

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

The requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) were not met. In particular, baths, showers and toilets of a sufficient number and standard suitable to meet residents' assessed needs were not provided.

**8. Action Required:**

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

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

The Person in Charge will ensure that the priority works are addressed in early May 2017 if the premises is needed for the current residents as an interim arrangement.

**Proposed Timescale:** 31/05/2017

## Outcome 07: Health and Safety and Risk Management

**Theme:** Effective Services

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

Key risks were not included on the risk register, including current safeguarding risks as a result of challenging behaviour and the inaccessibility of the premises.

**9. 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 risk register will be reviewed and updated to fully reflect all current risks including safeguarding risks and the inaccessibility of the premises

**Proposed Timescale:** 10/03/2017

**Theme:** Effective Services

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

Where there was a personal safety risk, it was not demonstrated that the risk assessment had been completed by a suitably competent person or that the control measures in place were proportionate to the level of risk. This potentially had an impact on residents' quality of life.

**10. Action Required:**

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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

A personal safety risk assessment will be completed to fully explore any potential risk and oversee appropriate and proportionate risk management controls.

**Proposed Timescale:** 28/02/2017

**Theme:** Effective Services

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

It was not demonstrated what plan was in place to evacuate residents in the event of a fire and bring them to safe locations, should a fire start when residents were asleep.

**11. 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:**

All Service Users Personal Emergency Evacuation Plans will be updated to provide clear guidance on night time evacuation procedures in the event of fire. Additional equipment such as an emergency evacuation chair will be kept on site

**Proposed Timescale:** 10/03/2017

**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:**

Some staff had not received training in relation to positive behaviour support, including de-escalation and intervention techniques.

**12. Action Required:**

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

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

All staff will receive training in positive behaviour support. Three staff received training on 20/02/2017 and the remainder will receive training by the end of April 2017.

**Proposed Timescale:** 28/04/2017

**Theme:** Safe Services

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

It was not demonstrated that adequate supports were provided for residents with behaviour support needs.

**13. 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:**

1. The Person in Charge will arrange a consultation with the Behaviour Support Service and Psychology to

- (a) determine interim strategies to be engaged pending the take up of the referral
  - (b) Determine the likely timeframe for the referral to be taken up and if necessary to
  - (c) Identify the need for external referral in relation to the matters identified in this consultation
2. The Person in Charge will monitor the referrals using the referral tracking form to ensure no significant delays occur following this consultation
3. As part of the residential transfer process for individual residents, the Person in Charge will consult with Behavioural Support Services in relation to the requirement to update behaviour support plans to support the residents in their planned new residential placements.

**Proposed Timescale:** 30/04/2017

**Theme:** Safe Services

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

Two actions were identified relevant to this regulation:

- a completed action plan that more clearly tracked the progress against each recommendation arising from the systems analysis investigation report was required.
- the provider had not implemented a safeguarding plan in full.

**14. Action Required:**

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

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

The progress on the implementation of recommendations for improvements in the safeguarding systems will be fully updated. [10 March 2017]

The protocol for the management of inappropriate placements including those which present as safeguarding risks will be finalised. [17 March 2017]

One resident will commence a phased transition plan to a new centre as recommended by ADT Committee from 27 March 2017. This will ensure the full implementation of the Safeguarding Plan by 30 April 2017.

**Proposed Timescale:** 30/04/2017

**Outcome 09: Notification of Incidents**

**Theme:** Safe Services

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

Significant failings were identified in relation to the statutory requirements to notify



incidents to HIQA or to provide updates in relation to the management of any allegation, suspicion or incident of abuse against residents.

**15. Action Required:**

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

The Person in Charge will review all incidents and ensure the required notification have been made to the Authority. Retrospective notifications will be submitted where necessary.

The Provider will introduce an incident log which will track notifications to the Executive and the Authority. This log will be reviewed on a regular basis and any gaps will be remedied as soon as possible. The log will be fully reviewed every quarter month.

The Provider will ensure that all concerns including systems weaknesses identified in relation to safeguarding procedures are retrospectively to the Authority and the outcome of the complaints in this regard will be updated to the Authority. Retrospective notifications will be made where necessary.

**Proposed Timescale:** 28/02/2017

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Improvements were required to the part of residents plans that related to healthcare.

**16. Action Required:**

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

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

Each Service Users healthcare plan will be reviewed and amended appropriately to fully reflect each service Users health care needs

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

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

The statement of purpose submitted to HIQA was dated 2015.

**17. Action Required:**

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

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

The updated Statement of Purpose will be submitted to the Authority.

**Proposed Timescale:** 31/05/2017

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not meet the requirements of schedule 1 of the regulations nor did it accurately reflected the premises and satisfactorily outline what services would be provided to residents.

**18. Action Required:**

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

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

The Statement of Purpose will be reviewed to ensure the requirements of Schedule 1 are met and the detail of the premises and services provided are accurately reflected in the Statement. This will be submitted when it is decided if renovations are required in May 2017.

**Proposed Timescale:** 31/05/2017

**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:**

Some improvements were required to the annual review to ensure that it adequately reviewed the safety and quality of care and support in the centre and assessed whether such care was in accordance with standards. A plan to address these issues was not clearly outlined in the annual review.

**19. Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of

the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

In future the annual review will detail all safety and quality of care issues and where required any shortcomings in relation to the standards, the report will give detail of how these will be addressed. An addendum will be put to the 2016 Annual Review in relation to how shortcoming identified in that review will be addressed.

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

**Theme:** Leadership, Governance and Management

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

It was not demonstrated that the unannounced visits adequately reviewed the safety and quality of care and support provided in the centre.

**20. Action Required:**

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

The Provider will review the format of the unannounced visits to the Centre to ensure that the safety and quality of care issues and actions taken in relation to these issues are reviewed and reported on as part of these visits.

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

**Theme:** Leadership, Governance and Management

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

Further clarity was required to provide reassurance that staff would be facilitated to raise concerns and in relation to the feedback mechanisms in place once concerns were raised.

**21. Action Required:**

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

The Provider will issue a communication policy and procedure that will clarify the steps to raising concerns and the feedback process.

**Proposed Timescale:** 16/03/2017

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

At this inspection, some gaps were identified in the training records that related to mandatory training and other training required to support residents' needs. This included training in relation to manual handling and training or instruction in relation to the use of the hoist or supporting residents who had fallen, training in relation to hand hygiene, infection control, risk assessment, food safety, personal planning and supporting residents with dysphagia.

**22. Action Required:**

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

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

The system of ensuring all essential training is undertaken by all staff and kept updated will be enhanced and where gaps have been identified appropriate training will be provided.

**Proposed Timescale:** 30/04/2017

### **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

The policy to inform the protection of vulnerable adults did not sufficiently outline the regulatory reporting procedures to be followed in the event of an allegation, suspicion or incident of abuse.

**23. Action Required:**

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

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

The Safeguarding Procedure will be reviewed to clarify the steps to be taken in the reporting of an allegation, suspicion or incident of abuse. This will be attached to the National Safeguarding Policy until this is reviewed in full by the Provider.

<b>Proposed Timescale:</b> 16/03/2017