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:	Telford Houses & Apartments
Centre ID:	OSV-0002314
Centre county:	Dublin 4
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Mary's Centre (Telford)
Provider Nominee:	Maura Masterson
Lead inspector:	Anna Doyle
Support inspector(s):	Karina O'Sullivan
Type of inspection	Unannounced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	4

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 compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
13 October 2016 11:00	13 October 2016 21:30

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

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

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of the designated centre. The purpose of this inspection was to monitor on going compliance with the regulations.

Description of the Service:
The centre is situated in South Dublin. It is part of a campus based setting and consists of apartments and three semi-detached houses. The apartments accommodate ten residents. Two of the houses can accommodate five residents and the other house can accommodate four residents. The centre provides care to female adults with a visual impairment, some of whom have an intellectual disability and health care needs. Care is provided using the social model of care, however nursing input is available as the person in charge is a nurse. The residents are supported to live independently with staff supports allocated on a needs basis.

How we gathered our evidence:
Over the course of this inspection the inspectors met six of the residents. All of the residents stated that they were very happy living in the centre, although most of them stated that they would like more activities at the weekend and in the evening times. The three houses were visited over the course of the inspection as well as one

of the apartments. The inspectors observed practices, met with staff, reviewed documentation such as: care plans, risk assessments, policies and procedures and the statement of purpose. The person in charge and the person participating in the management (PPIM) of the centre were not available on the day of the inspection.

At the opening meeting with the provider, the inspectors requested a number of documents in order to review them as part of the inspection. These included fire records, training records and personnel files. However, some of the documents provided were not up to date and inspectors were informed that the person in charge or the PPIM had some of these documents and they were not available on the day. The provider was asked to submit some records after the inspection date. This is discussed under the relevant outcomes in this report

Overall findings:
Overall the inspectors found that the residents who were met at the inspection appeared happy living in the centre and staff appeared respectful to residents. The two actions under outcome 13 and 18 were followed up from the last inspection; however, inspectors found that they had not been implemented.

Two major non-compliances were found under social care and workforce in the centre. Six outcomes was found to be moderately non compliant under health and safety, medication management, safeguarding, statement of purpose, governance and management and documentation. One outcome was found to be substantially complaint with some improvements required in healthcare needs. The action plan at the end of this report outlines the improvements required.

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

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
he inspectors found that residents had a written personal plan in place. However, significant improvements were required to ensure that arrangements were in place to meet residents' assessed needs.

The inspectors reviewed two plans with residents and found that an assessment of need had been completed. It gave details of residents' likes and dislikes, a description of their daily routine, their support needs in terms of independent living skills and detailed some goals set for the year. However, residents' healthcare needs were not included in the assessment of need.

Some residents had goals in place, for example going on holidays. However, some of the goals were not meaningful and did not outline how the goals would be met. For example a number of residents' plans stated that their goal was to remain as independent as possible but did not specify how this would be achieved.

In addition, one resident spoke to inspectors about a theatre show they had been looking forward to attending, but were told by staff that there were no tickets available. There were no records of this contained in the residents' personal plan and the resident was not aware if any alternatives had been considered.

While inspectors found that some residents had it recorded in their personal plan that they were happy to continue with their current daily routines, others informed inspectors they were not. For example, some residents said that there were no evening or weekend activities available to them outside of the centre. The majority of them stated

that they would like more evening activities that included going to the cinema, the local pub or the theatre. In addition, given that the centres focus was on independent living, it was not clear how life skills were taught in the centre and the supports residents required to maintain or enhance these skills.

A number of residents attended day services outside of the centre. Residents who remained in the designated centre had access to a resource room on the campus where different activities were scheduled each day. Some residents were observed attending an activity session on the morning of the inspection. However, at other times residents were observed to be sitting alone in the centre listening to music and not engaged in activity.

There was evidence that residents had participated in their personal plans. For example some residents had signed their plans. However, there was no review process in place to assess the overall effectiveness of personal plans.

One resident who spoke with inspectors had recently transitioned from the apartments to a house in the designated centre, stating that this had been at the request of a manager. Staff spoken with stated that the transition had been a result of an increase in the residents' needs and that it had been requested by the resident. Inspectors asked to see a copy of the transition plan for this resident. However, this was not available on the residents' personal plan.

The provider was requested to submit a copy of the records detailing this transition to HIQA. This was submitted and on review inspectors found that the transition for this resident had not been clearly recorded, the rationale for the move was not clear and the person in charge and the person participating in management were the only staff involved in the decision for this resident to transition.

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):
No actions were required from the previous inspection.

Findings:
The inspectors found that there were health and safety systems in place to protect residents. However, improvements were required in the management of risk in the centre.

The fire records for the centre were requested at the opening meeting. Inspectors found that some of the information made available was not up to date. The provider agreed to submit the most up to date records to HIQA after the inspection. On review the records showed that the fire equipment in the centre had been adequately maintained.

A fire drill had been completed by an external fire safety consultant in November 2015. This had been carried out when staffing levels were reduced in the evening time and no issues were identified on the records submitted. All staff had fire safety training in place. There were procedures in place for the safe evacuation of residents in the centre and it was displayed on residents' doors if they required assistance with an evacuation.

There was a risk management policy in place that contained the details set out in schedule five of the regulations. A separate policy was in place for the management of incidents in the centre and this was referenced in the risk management policy. A health and safety statement was also available in the centre.

There were some risk assessments in place specific to the centre for example smoking and independent living. However, not all identified risks in the centre had a risk assessment in place that recorded the control measures in place. In addition, some control measures in place could not be implemented into practice. For example one control measure stated that staff should supervise a resident during a specified activity, however this could not be implemented due to reduced staffing levels in the centre at night and in the evening time. Some risk assessments had not been reviewed within the specified time frames.

A copy of incidents that had occurred in the centre since the beginning of the year was made available to the inspectors. There had been eleven recorded incidents in the centre during this time period. From the sample viewed inspectors found that not all details were completed on the forms and while some control measures were recorded on the form to reduce the likelihood of a reoccurrence, there was no evidence of these control measures being implemented.

There was a policy in place for when a resident goes missing in the centre.

There were three vehicles available in the centre and a review of records found that they had a certificate of road worthiness in place.

There was a policy in place on infection control in the centre. However, inspectors observed one practice where this policy was not been implemented. For example inspectors observed recapped needles disposed of in the sharps box.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
The inspectors found that there were safeguarding measures in place in the centre; however, improvements were required in training for all staff in safeguarding vulnerable adults, the review of restrictive practices in the centre and behaviour support.

There was a safeguarding policy in place in the centre. Residents stated that they felt safe in the centre and would speak to staff if they were not happy or felt unsafe. Staff spoken to were clear about what to do if they suspected abuse. However, they were not clear about who to report an allegation to in the evening time. One staff stated that they would ring a manager even if they were off duty.

The provider was asked to submit a copy of the policy subsequent to the inspection to review reporting structures in place. The policy stated that all allegations should be reported to the manager. However, there was no manager on duty in the evening time or at night in the centre.

A record of staff training submitted to HIQA after the inspection, found that two staff had not received training in safeguarding vulnerable adults and the training provided for staff had not been updated to reflect the revised HSE safeguarding policy.

Inspectors were informed that there were no restrictive practices in place in the centre. However, on speaking to two residents, inspectors found that there were two restrictions in place for residents around access to certain items in the centre. Inspectors met with the two residents who knew what the restrictions were and stated that they were happy with these restrictions. However, there was no review process in place around these restrictions.

There was a policy in place for the provision of behaviour support. However, there were no care interventions in place on how to support residents who had behaviours that challenge in order to guide practice.

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):
No actions were required from the previous inspection.

Findings:
he inspectors found that residents' healthcare needs were for the most part were being met in the centre. However, improvements were required in some areas.

The inspectors found that residents had an assessment of need in place; however it did not include health care needs. From a review of residents' medication prescription sheets, some residents had no health action plans in place around healthcare needs to guide practice. Some examples included high cholesterol and mental health needs.

Residents had signed their care plan and one resident spoke to the inspectors about their personal plan. They were aware of an upcoming appointment regarding the dentist and were aware of the nature of this appointment.

Access to allied health professionals was primarily from services provided in the community. The inspectors found for the most part this was timely; however, one resident did not have access to an allied health professional for an assessed need since 2014. This was discussed at the feedback meeting and the provider informed the inspectors that referrals and follow up had been made. The records relating to this were asked to be submitted to HIQA after the inspection. On review the inspectors found that the information submitted related to another resident in the centre.

Residents had access to a general practitioner who visited the centre twice a week or residents could attend the local surgery if they wished.

Meals were provided from a central kitchen on the campus. Residents could attend the campus restaurant to have their dinner if they wished or could be facilitated to have it in the designated centre. Residents spoken to were happy with the choice of meals provided in the centre. One resident was observed having their evening meal alone in the centre, but informed inspectors that this was their own choice.

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):
No actions were required from the previous inspection.

Findings:
The inspectors found that there were arrangements in place to ensure that residents are protected by the designated centres' policies and procedures for medication management. However, improvements were required in a number of areas.

There was a medication policy available in the centre, which included a procedure for the disposal of medication. However, medications no longer in use were stored with regular medications.

In addition, on the morning of the inspection, inspectors observed that the second set of keys for the medication press were not securely stored in the centre.

A sample of medication prescription and administration sheets was viewed and the necessary details were recorded. Some residents were prescribed medication for diabetes. Staff in the centre administered this and were very clear about the procedures in place, both in terms of administering the medication and infection control guidelines. However, the inspectors found that staff were not clear when to administer one as required medication prescribed for a resident and there was no guide in place indicating when this should be administered.

The training records made available to inspectors on the day of inspection were no up to date. The provider was requested to submit the records to HIQA after the inspection. The records indicated that two staff had not completed training in the safe administration of medication.

Medications were audited in the centre. The last audit had been completed in September 2015 and regular audits were completed on medication administration sheets to ensure that the correct procedures were being implemented. The records of medication errors that occurred in the centre were not available on the day of the inspection.

Some residents self medicated in the centre. One resident talked to the inspectors about this process and were very aware of what their medication was prescribed for.

Controlled drugs were stored in the centre and the inspectors found that there were appropriate medication practices in place for this.

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:
The inspectors found that the action from the last inspection had not been implemented and significant improvements were required in the statement if purpose in order to comply with the regulations.

Since the last inspection the provider had undertaken to ensure that the care and supports provided in the centre were accurately reflected in the statement of purpose. This had not been completed.

In addition, the inspectors found that the document included information relating to another designated centre on the campus that provides care to elderly residents. Both the provider and the person in charge are responsible for the governance and management of this centre. This information was not relevant to this designated centre. Examples of some of the information contained included:

- The amount of residents in the designated centre was not correct and included details of residents from another designated centre

- The specific care needs that the designated centre is intended to meet.

- The services provided in order to meet those needs.

- The age range of the residents

- Any separate facilities for day services outside of the campus based setting.

- The organisational structure was not correct and included details of another designated centre on the campus.

This was discussed at the feedback meeting and the provider intended to rectify the document and submit a copy to HIQA once completed.

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:
The inspectors found that significant improvements were required in order to ensure that effective governance arrangements were in place to ensure that a quality service was being provided for residents in the centre at all times.

There was a defined management structure in place. The staff reported to a nurse who was a PPIM for the centre, the PPIM reported to the person in charge, who in turn reported to the provider nominee. Staff spoken to said that they had access to an out of hours on call service at weekends for support and advice. There were records indicating this on a notice board in one of the houses.

However, there were no clearly defined reporting structures in the evening times or at night. Staff spoken with said that they would ring their off duty manager if an issue arose. Another staff stated that they would seek over the phone advice from nursing personnel in the other designated centre on the campus if they required medical assistance.

In addition, there was no system in place for staff to report any safeguarding concerns. It was outlined in the service policy that staff should report concerns immediately to their line manager, suitable arrangements were not in place to support this directive.

The person in charge and the PPIM was not available on the day of the inspection. At the opening meeting the provider informed inspectors that in their absence they were responsible for the management of the centre. Inspectors acknowledge that this was an unusual occurrence. The inspectors were informed that the person in charge was also responsible for another designated centre on the campus. This centre provided care to elderly residents.

One unannounced quality and safety review had been completed in September 2016. This was made available to the inspectors but was not available in the designated centre on the day of inspection. This was a one page document and did not address the quality of care being provided in the centre. Instead it recorded whether the environment was clean. There were no actions from the review and inspectors found that the document

was not detailed enough. No other review had been completed since the last inspection and the provider confirmed this at the feedback meeting.

An annual review had been completed for 2014 - 2015 for the centre, however, it did not include consultation with the residents or family. Inspectors were shown a draft copy of the annual review for 2015- 2016 that was still in progress. In addition the inspectors were given a copy of the annual report from the health and safety committee for 2014 - 2015. This detailed progress to date regarding health and safety issues and further actions that needed to be implemented.

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):
No actions were required from the previous inspection.

Findings:
The inspectors found that the staffing levels in the centre were not sufficient to meet the social care needs of residents in the evening times and at weekends and significant improvements were required so as to ensure that the provider was meeting their obligations under schedule 2 of the regulations.

A copy of the staff rota was available in the centre; however, it did not include staffs full names or their role and title in the centre. Inspectors found that the roster in the centre was not planned around residents needs. For example, up to four staff were rostered up to five o'clock each week day, but only one staff was available in the evening times, at night and from two o clock in the afternoon at weekends.

When inspectors spoke to staff about how residents were supported to avail of evening/weekend activities they were informed that additional staffing would be scheduled as required. However, inspectors found that over a three month period no additional staffing had been made available in the evening times for residents and only one staff had been made available on Saturdays to support two residents accessing a community activity.

Only one sleep over staff was available at night-time. Residents' had individual panic

buttons in place in the event of them requiring staff assistance. This was linked to the main reception whereby the reception staff would ring the staff on duty in order to assist the resident.

Staff spoken to stated that they felt supported in their role. They informed the inspectors that the PPIM was available to meet with them every morning and that staff meetings were held every three months in the centre. The minutes of these meetings were not available at the inspection. In addition, staff stated that an annual staff appraisal was completed with the PPIM. However, the minutes of these were not available. The inspectors also found that the provider intended to introduce supervision on a more regular basis for staff but this was still in progress and senior managers were to receive training in this before the end of the year.

Inspectors found that the mandatory training records available on the day of the inspection were out of date for some staff and not available for others. In response the provider was asked to submit the training records for all staff to HIQA. On review of these records the inspectors found that some staff had not received training in the safe administration of medication and safeguarding vulnerable adults.

A sample of personnel files were viewed by inspectors and were found to contain the necessary documents, including garda vetting. However, there was no garda vetting in place for one student who the inspectors were informed was on an internship in the centre. The provider informed the inspectors that the person in charge had the garda vetting form for the student and therefore was not available to inspectors on the day of inspection. A copy of this was requested to be submitted to HIQA.

However, the information submitted did not give assurances to the chief inspector that the appropriate garda vetting was in place for this person. The provider was requested to submit written assurances to HIQA stating the interim actions they intended to take until this matter could be resolved.

Volunteers were employed in the centre. The inspectors reviewed a sample of volunteer files and found that garda vetting forms had been completed. However, the roles and responsibilities of volunteers were not set out in writing and there was no record to show how they were supervised and supported in their role.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities)

Regulations 2013.

Theme:
Use of Information

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

Findings:
The inspectors found that the action from the last inspection had not been implemented and further improvements were required in the maintenance of records in the centre.

Since the last inspection the provider had undertaken to ensure that the policies and procedures for the centre were written in a way that was specific to the designated centre. This had not been implemented. For example from the sample viewed, inspectors found that the policies and procedures for the centre referred to another designated centre on campus that was providing care to elderly residents.

In addition, the inspectors found that a lot of the information requested at the inspection was not easily retrievable. For example a record of staff meetings, supervision meetings for staff and up to date training records.

No other aspects of this outcome were inspected.

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:

Anna Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Mary's Centre (Telford)
Centre ID:	OSV-0002314
Date of Inspection:	13 October 2016
Date of response:	09 January 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessment of need for residents did not include healthcare needs.

1. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects

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

the resident's assessed needs.

Please state the actions you have taken or are planning to take:
The Centre is amending the resident's care plans to ensure that they all include a comprehensive assessment of needs including healthcare needs.

We are currently redeveloping our pre admission assessment of needs profile to make this more comprehensive, incorporating the health, personal, educational, social care needs and social activities of potential residents.

Care plans are being reviewed. Care plans will now include a section for the actions to support residents to achieve their goals. A section to document any training of life skills that supports independent living.

In-house training in care planning and case management has been arranged for January 2017. All existing care plans will be updated to include a comprehensive assessment of all the existing residents

Management have engaged Health Care Informed to carry out An Audit Programme for the Centre and this will include an audit of the care plans.

Following the inspection feedback a resident survey was carried on activities, social outings and daily routine. Following this, a comprehensive programme of activities and outings has been drawn up for the next two months. This includes outings to shows and concerts. Extra staff have been rostered to facilitate these outings. In consultation with the residents a number of social activities have been organised for the festive season, including Carol service by the Dublin Gospel Choir, Christmas parties, the Lyons Club, pop-up shop and the pharmacy for gifts.

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There no review process in place to assess the overall effectiveness of personal plans.

2. 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:
Currently Care Plans are reviewed every six months by staff and the resident. This is followed up with a multidisciplinary meeting of the Unit Staff. We will amend this process to have a formal Case Conference for each resident annually. This will involve resident participation, relatives/ personal representative if the resident wishes, ancillary support services and day services from the community. At each Case Conference the

findings and outcomes from each care plan will be reviewed to assess the overall effectiveness of the current care plan. A schedule for Case Conferences is being drawn up on a quarterly basis with the first scheduled to commence on Friday 2nd of December 2016.

Care plans are being reviewed. Care plans will now include a section for the actions to support residents to achieve their goals. A section to document any training of life skills that supports independent living.

In-house training in care planning and case management has been arranged for January 2017. All existing care plans will be updated to include a comprehensive assessment of all the existing residents.

Management have engaged Health Care Informed to carry out An Audit Programme for the Centre and this will include an audit of the care plans.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some goals set for residents were not meaningful and there were no records as to how goals would be met.

3. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
We will amend record keeping for goals of residents to ensure they are recorded with interventions required to achieve the goal, the timeframe involved, the person responsible for completing objectives and a review date. We have a section in residents care plan: My Day My Way, and we will add an additional page to encompass records of goals of residents.

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The transition of one resident moving from one area of the designated centre to another area was not clearly recorded and the rationale for the move was not clear.

4. Action Required:
Under Regulation 25 (4) (a) you are required to: Discharge residents from the designated centre 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:
Following the inspection management reviewed the process for the transition of residents from the independent living apartments to either the assisted living houses or to the nursing home. The procedure will now commence with a Case Conference involving all disciplines the resident and their relatives/ personal representative if the resident wishes. The meetings will be documented to recorded decisions and recommendations. This will be available in the care plans.

Proposed Timescale: Immediate effect November 2016 and on-going

Proposed Timescale: 09/01/2017

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:
Not all details were completed on incident report forms and while some control measures were recorded on the form to reduce the likelihood of a reoccurrence, there was no evidence of these systems being implemented.

Not all identified risks in the centre had a risk assessment in place that recorded the control measures in place.

Some risk assessments had not been reviewed in the specified time frames.

Some control measures recorded on risk assessments could not be implemented into practice. For example one control measure stated that staff should supervise a resident during a specified activity, however this could not be implemented due to reduced staffing levels in the centre at night and in the evening time.

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

Please state the actions you have taken or are planning to take:
Management have engaged Health Care Informed to carry out An Audit Programme. HCI will carry out comprehensive audits of the current service provision of the Centre. A comprehensive project plan is being developed covering the 12 month period. There will be 16 days of on-site audits by HCI over the 12 month period as follows:
- One Health & Safety Audit (3 days)

- Ten one day Audits of the Centre's processes (10 days)
- One Quality Review Audit (3 days)

Social Care Manager will ensure all risk assessments are completed and updated in the timeframe required for all residents.

Incident forms are sent to the Clinical Services Manager on a monthly basis. These will be discussed with the department managers at the monthly plenary meeting and reviewed by the Quality and Safety Team for trends. Risks identified will be included in the Risk Register with any controls identified to be introduced.

Staff will be refreshed on the incident reporting and documentation policy.

Since the inspection the Social Care Manager has introduced a programme to support residents who have ceased smoking.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Recapped needles were observed in the sharps box.

6. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
Social Care Manager is liaising with the community public health nurse to make arrangements for her to administer all Intermuscular medications. All staff will be reminded of the Centre's infection Control Policy, the needle stick injury protocol and sharps disposal policy.

Proposed Timescale: 28/02/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no care interventions in place on how to support residents who had behaviours that challenge to guide practice.

There was no review process in place around two restrictive practices in the centre.

7. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
We are liaising with mental health services on an on-going basis regarding the manner to best support residents with challenging behaviour and how residents are responding to consistent team approach. Due to complex medical diagnosis a resident will present with behaviours that challenge on occasion but episodes have decreased significantly from weekly and monthly basis to an occasional basis. A care plan has been drawn up to instruct staff on the most effective way of dealing with the behaviour.

On first of October 2016 the Centre facilitated staff to attend responsive behaviour training to support working in a positive fashion with behaviours that challenge. In addition the Social Care Manager is actively pursuing the HSE with the goal of getting the support of a behavioural psychologist to work with the resident and staff so a more specific detailed care plan for the resident's challenging behaviour may be devised.

All restrictive practises have risk assessments and care plans in place. The Social Care Manager will take responsibility to ensure these are reviewed and updated in a timely manner. The restrictive practices at the time of the inspection are no longer in place as residents have been assisted to cease smoking.

Proposed Timescale: 30/03/2017
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The safeguarding training provided, did not reflect the new HSE policy on safeguarding vulnerable adults.

Two staff had not completed training in safeguarding vulnerable adults.

8. 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 Centre has designated officers trained in HSE Policy on safeguarding vulnerable adults. Management are awaiting dates from the HSE for staff to attend train the trainer safeguarding training and then arrange in-house training of all other staff. The Social

Care Manager has contacted the National Safeguarding Office in the HSE and was advised that train the trainer training may be coming up in early 2017. In the meantime we were advised to continue with the previous HSE elder abuse training. As advised management continue to train staff in elder abuse.

A designated officer has offered to attend any dates for the train the trainer at short notice.

The Centre's policy has been updated to incorporate the National Safeguarding Policy. All staff have been informed and Safeguarding posters from the HSE are displayed throughout the Centre.

Proposed Timescale: 30/03/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no senior person identified to report allegations to in the evening time or at night.

9. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
The Centre has a weekend manager on-call system. Management are currently reviewing this system to include evenings and night time so there will be a designated manager on-call at all times. The on-call list shall be reviewed and amended to reflect these proposed changes. This arrangement will be dependent of approval of funding from the HSE. In the meantime there are six trained designated officers in the Centre and the practice is that managers can be called when off duty in the event of any emergency including a safeguarding allegation. Telephone numbers are listed in the emergency plan, at reception and on each unit.

Proposed Timescale: 16/12/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident had no access to an allied health professional since 2014, for an assessed need.

10. 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:
All residents care plans are being amended to include information and recommendations from allied health professional. Following a case conference for each resident care plans are reviewed on a six monthly basis. Residents and their representatives will be involved in this process and allied Health Professionals will be invited to attend. Care plans will be updated to reflect any changes including any recommendations from allied health professionals.

At the time of the inspection the medical files for the residents were stored in a secure location in the main centre to ensure confidentiality is protected. The inspector was not shown the location of the medical files on the day of the inspection.

Proposed Timescale: 30/04/2017

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no health action plans in place for some residents healthcare needs.

11. 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:
Currently we have separate medical files for residents which are stored separately and monitored by their GP. Care plans now include health action plans for health related issues with feedback from the GP, hospital appointments, other ancillary support services and allied medical professions without breaching any medical confidentiality.

Proposed Timescale: 09/01/2017

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 second set of drug keys were not securely stored in the centre.

12. 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:
Staff have been reminded of their responsibility to keep the keys in a secure location at all times and to utilise the key box for safe storage.

Training in medication management with City Pharmacy is arranged for all staff on 22nd December 2016. This will enable our relief staff to attend.

Proposed Timescale: 22/12/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some unused medications were being stored in the drugs press and were not segregated from regular medications.

13. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
Training in medication management with City Pharmacy is arranged for all staff on 22nd December 2016. This will include protocols on how to administer, store and segregate medications. Going forward all unused drugs will be returned to the pharmacy in a timely manner.

A medication audit of the Centre was carried out by City pharmacy in April 2016. The findings of the audit was discussed with staff.

Proposed Timescale: 22/12/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not clear when to administer one as required medication prescribed for a resident and there was no guide in place indicating when this should be administered.

14. 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:
Training in medication management with City Pharmacy is arranged for all staff on 22nd December 2016. This will include protocols on how to administer, store and segregate medications.

A meeting will be held with City Pharmacy to discuss establishing an effective programme of medication reviews. At this meetings Management will bring to the attention of the pharmacy findings from outcome 12 of the inspection report and discuss actions to address these. City Pharmacy will liaise with the GP's to ensure the medication reviews are carried out effectively.

Proposed Timescale: 31/01/2017

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 contained details pertaining to another designated centre on the campus.

The statement of purpose did not contain all of the requirements under Schedule 1 of the regulations some of which included:

- The amount of residents in the designated centre was not correct and included details of residents from another designated centre

- The specific care needs that the designated centre is intended to meet.

- The services provided in order to meet those needs.

- The age range of the residents

- Any separate facilities for day services outside of the campus based setting.

- The organisational structure was not correct and included details of another designated centre on the campus.

15. 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 and function has been amended to separate the Centre from the other registered designated centre on the campus.

The Centre does not have separate facilities for day services outside of the campus based setting. Residents attend day centres belonging to other services.

The details of the organisational structure includes details of the managers in the other designated centre as these provide out of hours on-call services to the whole Centre. The Centre as a whole is funded under Section 39 of the Health Act and has been providing services as a Voluntary Body for more than 25 years. The organisational chart represents the whole structure of the Centre.

Proposed Timescale: 09/01/2017

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:
There was no effective reporting system in place in the evening times or at night time during the week.

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

Please state the actions you have taken or are planning to take:
The Centre has a weekend manager on-call system. Management are currently reviewing this system to include evenings and night time so there will be a designated manager on-call at all times. The on-call list shall be reviewed and amended to reflect these proposed changes. This arrangement will be dependent on approval for funding from the HSE.

Currently the Person in Charge and the Registered Provider have an arrangement that one is always in Dublin and available for the purpose of reporting emergencies. Reception staff are informed of their availability and this is documented in the reception diary. Contact details for managers are available in the emergency plan, at reception, and on each unit.

Reception staff/ security staff are informed when there is an emergency and they contact the managers.

Proposed Timescale: 16/12/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was only one unannounced quality review completed since the last inspection.

The unannounced quality review completed in September 2016 was not detailed enough so as to effectively monitor the quality of care being provided in the centre.

17. 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 registered provider works full time in the Centre and is present every weekday and occasionally visits on weekends unannounced. The registered provider will carry out unannounced inspections of the Centre at least every six months and will document this in line with the regulations.

The quality of care is discussed on a weekly basis by the management and formally at monthly management team meetings .

Management have engaged Health Care Informed to carry out An Audit Programme. HCI will carry out comprehensive audits of the current service provision of the Centre. This will include a Quality Review Audit over 3 days.

Proposed Timescale: 31/12/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review completed for 2014 - 2015, did not include consultation with resident's or their representatives.

18. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
The Centre has completed a resident satisfaction survey and an activities survey. The

results of these surveys are discussed at the residents' council meetings and feedback will be included in the 2016 annual review report.

Management will conduct a satisfaction survey with the residents' relatives/ personal representatives should the residents wish them to be involved.

Proposed Timescale: 30/12/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff rota did not include staffs full names or their role and title in the centre.

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

Please state the actions you have taken or are planning to take:
The staff roster has been amended to include the full name of all staff and their role included also.

Proposed Timescale: 09/01/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient staffing levels in the evening time and at week ends in order to meet residents social care needs.

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

Please state the actions you have taken or are planning to take:
The roster is continuously adapted to meet the needs of residents. In the attached roster scheduled from 26th November to 30th December extra staff are scheduled on Saturdays to facilitate residents engaging in social activities. There are four trips and 15 events scheduled over this period.

In addition we completed a survey with residents on satisfaction levels in relation to social activities. We received a very positive response with 99% of residents saying they are happy with the current level of activities they participate in. However 50% of

residents say they might like to go out more often in the evening and this is being facilitated as outlined in the paragraph above.

Some residents do not like to go out in the dark evenings as it impacts on their visual impairment and they prefer day events. We have taken all feedback on board and ensure we offer opportunities for residents to engage in as much social activities as they would like.

Proposed Timescale: 09/01/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Garda vetting had not been completed for an intern student on placement in the centre.

21. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
The intern student was removed from placement for two weeks until Garda Clearance was received. This is now on the intern student's file as are all other documents under Schedule 2.

The Management Team will communicate to all managers the details of the documents to be held in respect of each member of staff. Managers and will be provided with a copy of Schedule 2 of the Regulations 2013 for them to reference. A memo will be circulated to all current staff detailing the records in Schedule 2 which they are required to provide and keep updated for their personnel file. The New Employee Packs has been updated to include a document informing all new employees of the documents they are required to provide under the Regulations 2013 prior to commencing with the Centre.

An in-depth audit has been carried out on all personnel files to ensure that all Garda Vetting is up to date and any gaps in C.V.'s are accounted for. This also included the translation of all certificates to English.

Proposed Timescale: 16/12/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two staff had not completed training on the safe administration of medication.

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:
Training in medication management with City Pharmacy is arranged for all staff on 22nd December 2016. This will enable our relief staff to attend.

Proposed Timescale: 22/12/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities of volunteers were not set out in writing.

23. Action Required:
Under Regulation 30 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in writing.

Please state the actions you have taken or are planning to take:
All volunteer files will be audited to establish the volunteer duties and responsibilities of each individual volunteer. Duty descriptions detailing the roles and responsibilities will be drafted for each volunteer, agreed and signed. A copy of the duty description will be held on each volunteers file. The unit manager will be responsible for supervising the volunteers on their unit.

Proposed Timescale: 30/04/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no records to show how volunteers were supervised and supported in their role.

24. Action Required:
Under Regulation 30 (b) you are required to: Provide supervision and support for volunteers working in the designated centre.

Please state the actions you have taken or are planning to take:
In addition to detailing the roles and responsibility of each volunteer in a duty description as outlined in Action 24, this document will inform the volunteer of the reporting lines associated with their voluntary duties along with the name of the person providing supervision and support to them when volunteering in the Centre.

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 policies and procedures for the centre were not written in a way that was specific to the designated centre.

25. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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 Centre's current policies and procedures were designed to cover the Centre has a whole. Management are working with Health Care Informed to separate the policies and make these Centre specific to the Disability Sector.

Proposed Timescale: 31/12/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the information as set out in schedule 4 of the regulations was not available in the centre on the day of the inspection.

26. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
Management are reviewing the storage of records of the various meeting so that in future it will be easier to access in the event of the absence of the Person in Charge or the Social Care Manager.

The Person in Charge and the Social Care Manager will attend Supervision training in January and a more formal structure for supervision meetings for staff will be set up and records will be maintained.

Proposed Timescale: 16/02/2017