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:	Centre 2 - Aras Attracta
Centre ID:	OSV-0004910
Centre county:	Mayo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Suzanne Keenan
Lead inspector:	Stevan Orme
Support inspector(s):	Christopher Regan-Rushe; Thelma O'Neill
Type of inspection	Announced
Number of residents on the date of inspection:	17
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
16 May 2017 09:50	16 May 2017 19:00
17 May 2017 08:30	17 May 2017 19:20
18 May 2017 08:20	18 May 2017 14:32

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

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

Summary of findings from this inspection

Background to the inspection:
This was an announced inspection which was completed in order to inform a decision on the registration of the centre.

Over the last three years, this centre has been subject to an increased regulatory monitoring programme, due to significant concerns relating to the safety and wellbeing of residents who lived in the centre. In September 2015 the provider was issued with a notice of proposal to cancel the registration of this centre, as a result of

a continued failure to address these concerns. In response to the notice the provider made written representations to the Office of the Chief Inspector, setting out the actions it had taken and would continue to take to bring the centre back into substantial compliance with the regulations. Following on from this response an increased regulatory monitoring programme was developed by the Health Information and Quality Authority for each of the three centres located on the Aras Attracta campus.

Over the course of the monitoring programme, inspections have been completed to monitor the progress and actions the provider has taken to bring the centres into compliance with the regulations and standards.

During this inspection, inspectors also reviewed the actions the provider had said they would take following the centre's previous inspection, conducted on 20 and 21 October 2016.

How we gathered our evidence:
During the inspection, the inspectors met with all 17 residents at the centre either in small groups or individually. Inspectors also met and spoke with family members and sought their opinions, both verbally and in questionnaires, about the service provided in this designated centre. In addition, inspectors met with a range of staff and observed support practices throughout the inspection. Inspectors also reviewed documentation relating to residents' needs and the operational management of the centre; such as, personal plans, health records, risk assessments, policies and procedures and staff files.

Where residents were able to tell the inspectors about the service they received, they were not complimentary and said that they were unhappy and wished to move from the centre. Where residents were unable to tell the inspectors about the quality of support they received, inspectors spent time observing residents' interactions with staff. Inspectors found that residents appeared relaxed when supported by staff. However, although staff were caring, inspectors found that staff knowledge of residents' needs was inconsistent, not all staff had received up-to-date training and there was a reliance on temporary workers at the centre. Inspectors spoke with family members during the inspection, who said that although they were happy with the support provided and found staff to be caring, they felt there was a high turnover of staff which resulted in new and unfamiliar staff supporting their relatives. Relatives also told inspectors that they felt their relatives' needs were not fully met by the provider; for example, in relation to communication and transition planning to new homes in the community.

The inspectors interviewed the person in charge as part of the inspection and found that she was suitably qualified and knowledgeable on residents' needs.

Description of the service:
The provider had produced a document called the statement of purpose, as required by the regulations Inspectors found that the service was not accurately described in that document in relation to services and facilities provided to meet residents' needs following recent reconfigurations at the centre.

The designated centre is part of a large campus operated by the Health Service Executive in Mayo. The centre provides full-time seven day residential services to 17 adults with a disability. The centre comprised of six bungalows which were configured into either single or multi-occupied bungalows and was close to a nearby town with easy access to all local amenities and shops.

Overall Findings:
During this inspection inspectors found that the provider's governance and management systems had failed to ensure a safe and good quality service was being provided to meet residents' assessed needs.

Due to significant concerns about the arrangements that the provider had for the safeguarding of vulnerable adults and for ensuring fire safety, the provider was issued with three immediate actions in relation to regulations:
8 (2) : The provider had not ensured that residents were adequately protected from the risk of abuse
28(2) (c) : The provider had not provided emergency lighting in full working condition in parts of the centre
28(3) (d) : The provider had not ensured adequate means of evacuation for all residents at the centre

Following the previous inspection, the provider submitted an action plan to HIQA containing 31 specific actions. Inspectors found that 27 of the 31 actions had not been completed.

The centre was inspected against eighteen outcomes. Inspectors found major non-compliance in ten outcome areas including key areas of safeguarding, risk management and residents rights. Moderate non-compliance was found in six outcomes and two outcomes were found to be compliant.

The inspectors found that following the previous inspection, the provider had reconfigured the larger bungalows within the centre to reduce occupancy levels which had provided more communal and private space and improved the quality of life for some residents.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that the provider had reduced the number of residents living in the centre since the last inspection. This had a positive impact for some residents. However, inspectors found that there was a continued reliance on institutional practices in the management of tasks and the provision of support to residents. Inspectors found that improvements were also required to how the provider listened to and responded to complaints made by residents in the centre.

Inspectors found that residents and their families knew how to express concerns about their care. However, residents and their families told the inspectors that they did not feel that their complaints were listened to and that they would be responded to. For example, during the course of the inspection, one resident explained to inspectors how the failure of staff to respond to their request for a replacement battery for their wheelchair was impacting significantly on their independence. Inspectors discussed this with staff on duty who advised them that the battery had been purposely removed from the residents chair for safety reasons. Staff said that this had not been discussed with the resident, there were no records of her complaint and there were no records of how the complaint was responded to. This impacted significantly on the resident's ability to mobilise and the resident's concerns and complaints were not responded to. Inspectors observed that the resident continued to try to use the wheelchair and had resorted to shuffling their feet in order to manoeuvre the chair.

Other residents told the inspectors that they had raised verbal complaints in residents' meetings. However, no investigation into these complaints had been undertaken. The

inspector discussed these concerns with staff and the person in charge and found that the provider had failed to respond to these complaints. The inspector also saw examples of where family members had made complaints which had not been responded to. For example, a complaint relating to the healthcare of a resident had been sent in a letter but there was no evidence in the complaints log that the complaint had been received and responded to.

In some of the bungalows inspectors found that there were regular residents' meetings where residents could express their views and choices about their care and support. However, in other bungalows, these meetings were not occurring and residents were not being actively supported to engage in the overall running of the centre and choices about their day to day activities. When inspectors reviewed the follow up to residents who had expressed choices and preferences for activities during these meetings, it was found that staff were often unable to respond to the suggestions of residents due to the way in which the daily routine was organised in the centre. For example, morning routines were found to continue to focus on the administration of medication, staff breaks and the preparations for lunch with little opportunity to follow through on residents' suggestions.

Inspectors found that residents who had 2-to-1 staff support were able to actively pursue their goals. However, residents who did not require this level of enhanced support were frequently unable to pursue their personal goals and any activities tended to be in large groups because of staffing availability. For example, a resident told inspectors that as part of their personal plan they were to have regular community activities each day but that they were only being supported to do this twice a week. This action had been raised as a concern with the provider at a previous inspection.

The provider had told the office of the chief inspector that two new staff would be employed to focus on improving daily activities outside the centre for these residents. One of these members of staff had been on long term leave from the centre and had not been replaced. Inspectors found that no activity programme had been developed to enhance community engagement for residents and the majority of activities for resident continued to occur in the bungalows around the staff routines of the day.

Judgment:
Non Compliant - Major

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Overall, inspectors found that the provider had taken steps to Improve support to residents in relation to their communication needs. However, the provider had failed to ensure that staff had the required skills to effectively implement the communication plan for one of the residents with specific communication requirements.

Inspectors looked at a sample of residents' communication passports which showed that residents communicated their choices through sign language, objects of references and photographs. Inspectors found that this was reflected in staff knowledge. However, inspectors found that not all staff had received communication training. One resident's family member expressed concerns to inspectors about the inconsistent use of sign language and use of communication aids, due to high levels of staff turnover and centre's reliance on temporary workers. Inspectors also found that there was a high turnover of staff and a reliance on agency staff who changed regularly.

Although residents had access to the television, radio and newspapers and two residents' had access to personal computers or tablets, inspectors found that no assessments had been completed on whether assistive technology could further assist residents' communication needs.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Residents were supported to develop and maintain personal relationships with their families and the wider community. Families were encouraged to be involved in the lives of residents. Inspectors found that there were positive relationships between residents and their family members and these relationships were supported by the staff in the centre.

Since the last inspection, arrangements had been put in place for each resident to receive visitors in private, with no restrictions on family visits, except when requested by the resident. In addition, inspectors found that families were kept informed of residents' well-being and families and residents attend personal plan meetings and reviews, in accordance with the wishes of the resident.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Inspectors found that there was an up-to-date admissions policy, which stated that no new admissions would be made to the designated centre. In addition, while the provider had ensured that each resident had a written agreement in place, which was signed by either the resident or their representative, these were not sufficiently transparent and did not include details about the fees and charges that the resident would be required to pay.

Inspectors reviewed a sample of residents' written agreements, which included details of the services and facilities at the centre. However, inspectors found that each agreement stated that the residents' contribution to the costs of their support would be determined following a financial assessment. While these financial assessments had been completed, the written agreements had not been updated to reflect each resident's contribution. In addition, the written agreements did not include sufficient detail on whether the resident would be liable for any additional charges while resident at the centre, such as charges for healthcare, community activities or transport costs.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors found that some actions arising from the last inspection had not been completed. Inspectors found that, apart from four residents who moved to a new bungalow, there had been little improvement since the last inspection for the remaining residents in relation to social care. There was poor implementation and monitoring of their personal plans. In addition inspectors found that some resident's personal plans had not been reviewed on an annual basis, at a minimum, as required by good practice and by the regulations..

Inspectors found that the provider had opened an additional bungalow on the campus to enable four residents to move into a less crowded setting. This had a positive impact on the residents who had moved into the new bungalow, located in another centre on the campus.

Inspectors reviewed a proportion of residents' personal plans and determined that residents were not being consistently supported to access activities in line with these plans and their personal preferences. Residents and staff told inspectors that this was due to the insufficient number of suitably trained staff who could administer medications and the lack of availability of suitable wheelchair accessible transport.

Of the sample of residents' personal plans examined by inspectors, two had not been reviewed on an annual basis and were last reviewed in May 2015. Where reviews had occurred inspectors found that they focused on the healthcare and mobility needs of the residents and did not adequately identify the residents' social care preferences or how effective the previous plan had been in meeting the residents' needs. In addition, inspectors found that the reviews lacked the involvement of the resident and/or their representative, that they had not been kept updated and did not include key aspects of the residents' needs, including the management of behaviour that challenges.

In personal plans where goals had been identified, inspectors found that these did not include the name of the person who would support the resident achieve the goal. In addition, the goals did not have a timescale for their achievement. Inspectors also found that the provider had failed to make these plans available to residents in an accessible format.

Inspectors reviewed the transitional plans that had been developed to support residents to move to community dwellings in the future. These included plans for residents in this centre to transition to new living arrangements during the second half of 2017. Inspectors found that these plans had been developed in consultation with the residents and their representatives. However, the transition plans did not include details of when or where the resident would transition to. In addition, one resident's family member told

the inspectors that they were not assured that the transition plans would meet their relatives' needs. This was of concern given the imminent implementation of the plan.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Inspectors found that the actions from the last inspection had not been suitably completed. While the provider had discharged four residents, which had improved the quality of life for some residents in the centre, there continued to be a large variance in the standard of the environment across each bungalow in the centre. In particular, inspectors found that improvements were required to the internal and external maintenance, access to suitable bathroom facilities and the completion of planned renovation work to kitchens.

Some of the residents had been involved in choosing the paint and soft furnishings for their bedrooms and where these rooms had been renovated, they appeared homely and comfortable. For example, some residents had been able to choose the style of bed that they would like and their own linen. In other bungalows work had yet to commence on the renovations and they continued to have an institutional appearance with poorly maintained kitchens, damaged ceiling tiles and the use of hospital style beds. In a respite house in the centre, the bedroom door had a large clear glass panel which compromised the privacy of residents, while other doors had viewing holes into the bedrooms.

An inspector spoke with maintenance staff and the provider about the general maintenance of the centre and were advised that planned and routine maintenance had been stopped in the centre and a reactive approach to maintenance was now in place. Staff highlighted a number of areas of repair that needed attention including damaged ceiling tiles in resident areas, damp areas, hazardous debris on emergency exit routes and damaged and leaking guttering around the bungalows. While staff advised that these issues had been reported for repair, there was no central log of these and no records of when the issues would be resolved. In addition, inspectors found that there

was a lack of oversight of the general state of the centre by the provider and no evidence of regular review or audit of the environment to ensure that this remained fit for purpose and in a good state of general repair.

Inspectors reviewed resident's access to aids and equipment and found that there was poor oversight of the provision and use of assistive equipment. Inspectors saw examples of situations where residents had not been appropriately assessed for the use of assistive equipment or had been assessed but the assessment had not been implemented. In once example, inspectors saw where one resident was using their wheelchair without the recommended pressure relieving cushion and had a towel placed underneath them instead. This resident had been assessed by a healthcare professional and the assessment had been implemented. However, subsequent changes had been made to the arrangements without consultation with the healthcare professional. The inspector found that the wheelchair appeared dirty and did not have a schedule in place for its regular cleaning.

Recent changes to the internal structure of one bungalow had been made to improve the experience of one resident. However, this had affected the ability of the remaining residents to choose to have a bath or a shower, due to the locations of these rooms and the now limited access to alternatives.

Inspectors found that some residents did not have access to kitchen facilities in their bungalow and the kitchen in another bungalow was scheduled to be replaced. However, addressing this had been one of the provider's own actions from the October 2016 inspection and this had still not occurred by the time of this inspection. This was impacting on the residents' ability to be involved in meal preparation. Furthermore, most residents were not supported to fully utilise their kitchens and their continued to be a reliance on the central kitchen on the campus to provide most of the meals for the residents.

Communal rooms were generally comfortable and some were tastefully decorated while others were small and lacked character and decoration. Storage facilities were not utilised appropriately. Inspectors found the storage rooms were locked but on entry, the rooms were not tidy and cleaning staff could not access the sinks. A centralised laundry service was used for residents' linen and towels and some houses had a washing machine and a dryer available for residents to use. However, inspectors observed that some residents did not have laundry facilities in their bungalow leading to residents having to bring their laundry to other bungalows in the centre for washing.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Inspectors found that the provider's health and safety and risk management systems did not adequately promote and protect the health and safety of residents, visitors and staff. Inspectors found that the actions arising from the previous inspection had not been addressed and that there continued to be significant risks posed by the provider's management of accidents and incidents, fire safety, falls management and the control of infection within the centre.

Inspectors issued two immediate actions to the provider during the course of the inspection, due to the poor management of fire safety and evacuation procedures. Overall inspectors found that the provider did not have adequate arrangements for the evacuation of residents from part of the centre, that residents who were at risk of choking were not adequately protected and there was poor management and oversight of falls prevention within the centre.

Inspectors reviewed fire safety measures in the centre and found that in two bungalows the emergency lighting was broken. The person in charge of the centre advised the inspectors that they were aware of the issue but no action had yet been taken to resolve the issue. Due to the risk posed to residents the inspectors issued an immediate action to the provider, requiring them to ensure that adequate emergency lighting was in place in the bungalow. The provider responded to the immediate action by arranging for temporary emergency lighting to be installed in the centre. However, in doing inspectors found that the provider had not properly assessed the impact of their actions on residents. The provider failed to appropriately risk assess the location of these lights, which were on stands and had long trailing wires. They blocked emergency escape routes from the centre, were trip hazards and there was a significant increase in the risks to residents. The provider was required by the inspector to take further action to ensure that the hazard was removed from the centre and that residents could be effectively evacuated from the centre in the event of an emergency.

Inspectors showed the director of services the hazards found regarding the emergency escape routes, including the lack of pathways, sinking ground caused by a leaking roof gutter, no emergency lighting to the rear of the building, and two gates, one locked and another that residents could not open - preventing them from exiting from the rear and side exits of the bungalow. The director of services confirmed that a temporary surface would be put in place immediately and a permanent surface would be put in place the following week to ensure safe fire evacuation routes from the bungalows.

The inspectors reviewed the overall fire safety measures in the service and found there continued to be inadequate measures in place to contain the spread of fire in the centres. The provider had a fire consultant review the centre and this person had advised that the current internal doors were not sufficient. The provider had previously told the Office of the Chief Inspector that fire doors would be installed in the centre by

31 May 2017. During the inspection, inspectors were told that while the provider was working towards achieving this action, the fire doors had not yet been installed. Inspectors were given correspondence from the director of services advising that these fire safety measures would be prioritised, once funding was received.

Inspectors found that since the last inspection the provider had arranged for a visit by the local fire service to the centre and that fire drills were being regularly carried out. Inspectors discussed the fire evacuation plan with staff on duty on the days of the inspection and found that some staff were unfamiliar with the evacuation plan. A review of training records demonstrated to inspectors that the provider had failed to ensure that all staff had received fire safety training, as required by the provider's policy.

The provider had developed a new local risk management policy and a risk register which was regularly reviewed and updated. The provider produced a document which detailed that there had been an overall reduction in the risks in the centre by 60%. However, the person in charge could not demonstrate to the inspectors how this figure had been derived. While the provider's risk management policy for the centre was informative, inspectors found that the policy did not contain all of the requirements of regulation 26. For example, it did not contain the measures and actions staff should take in the event of an unexpected absence of a resident, accidental injury to residents, visitors, or staff or the occurrence of aggression and violence and self harm.

In addition, the risk register maintained by the centre did not adequately identify and mitigate all of the risks in the centre. For example, inspectors reviewed a number of records relating to accidents and incidents that had occurred in the centre and found that the provider had failed to introduce adequate controls to reduce and prevent the risk of falling. Inspectors found that five residents had experienced frequent falls, two residents had fallen on 14 occasions and three residents had each fallen on over 20 occasions over a ten month period. Many of these falls were unwitnessed. Inspectors found that while incident records had been maintained, they did not routinely identify the cause of the fall, the learning and actions taken in order to reduce or prevent the risk of further falls and whether the residents had required medical attention following the fall. Inspectors found that while the provider had started to take measures to set up a falls management committee they did not have a falls prevention and management policy in place to support and guide staff in the management of falls and had failed to ensure that all staff had received training in moving and handling. This had also been an action from the previous inspection.

The inspectors reviewed how the provider took learning from incidents and whether this learning was shared with the staff team. Inspectors found that while accidents and incidents were being recorded in the centre and discussed in management incident report meetings, the person in charge had not shared this learning in staff meetings or taken appropriate action to reduce or mitigate the risks in the centre. For example, there had been a serious choking incident in the centre and the provider had still failed to implement appropriate risk management assessments and control measures to prevent similar incidents occurring. Inspectors found that three residents were identified as having several incidents of choking and suffering from aspiration due to eating unsuitable food or non-edible items, such as plastic. Some of these incidents had required staff intervention to assist the residents regain an airway, and staff had

responded in a timely manner. However, inspectors found that recommendations had been identified following these incidents and they had not been implemented.

Furthermore, one resident, who required a surgerical procedure to assist them with swallowing and reduce their risk of choking, had their procedure cancelled and delayed for a further two months as staff had not ensured that the resident received the required pre-medication prior to this procedure. The inspector requested an investigation into this issue and the provider has confirmed that they are investigating the matter.

During the last inspection it was found that the provider was not storing therapeutic liquid oxygen cylinders in line with recommended guidelines. During this inspection, inspectors found that while the provider had now removed cylinders from communal areas, in one bungalow two oxygen cylinders were found to have been left unsecured and not stored in line with this guidance. In addition, inspectors found that the storage of medical devices did not ensure that adequate infection control measures were being taken by the provider to prevent or reduce the risk of residents acquiring a Healthcare Associated Infection (HCAI). For example, a suction machine, used to help residents maintain a clear airway was found to be stored in the entrance hallway of one bungalow and was not clinically cleaned.

Inspectors reviewed the cleaning protocols in place for the centre and noted that they failed to ensure that medical equipment was being routinely cleaned in line with best practice guidelines. In addition, inspectors found that the provider had failed to ensure that staff were adequately trained in the reduction of infection control risks, as outlined in their own policy, with only 4% of staff trained in hand hygiene and 2% of staff trained in infection control prevention.

The overall management of the risks relating to the maintenance of the centre was found to require significant improvement. Inspectors found that there was no overview system in place to assess, monitor and review the actions put in place to mitigate the risks in the centre while repairs were being progressed. For example, inspectors found that there was damage to the locking mechanisms for secure cupboards where items which may pose a risk to the health and safety of residents were stored, including medical devices such as needles and syringes. The provider and person in charge had failed to identify this as a risk and to ensure that this was reported for repair. Inspectors met with the maintenance supervisor who stated that all routine and planned maintenance work had been stopped in the centre and the focus was now on reactive work and there were no systems in place to monitor and prioritise defects in the centre using a risk register or a log of all incomplete maintenance work. An inspector spoke with the person representing the provider, who confirmed that there was no current system in place to enable an effective overview of all of the outstanding repair works in the centre to help determine the level of risk that these may pose to staff and residents.

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:
Inspectors found that the provider had failed to ensure that adequate measures were in place to protect residents from the risk of being harmed or abused. In addition, Inspectors found that the provider had failed to appropriately investigate allegations of abuse raised by residents. While the provider had ensured that a review of restrictive practices had been completed and that there were now up-to-date protocols in place for the use of medication for the management of behaviours that challenge, inspectors found that the person in charge had not given adequate consideration to the impact of restrictive practices on other residents in the centre who did not require such measures.

Due to the concerns relating to the safeguarding arrangements and the management of restrictive practices, the provider was issued with an immediate action requiring them to respond to the safeguarding issues that were identified in the centre.

An example of a safeguarding issue related to a resident who met with inspectors and told them that she did not feel safe living in the centre and that she had expressed a number of concerns alleging that staff were not treating her in a respectful manner. Staff told the inspectors that this resident would make allegations very frequently and that they had been advised to record the allegations in a 'blue folder'. Inspectors reviewed the contents of the blue folder and found that a log was being taken of all comments that the resident was making to staff; many of which were making complaints and allegations about the care and treatment she was receiving. The designated officer told the inspectors that there was no active safeguarding plan in place for this resident. Inspectors found that the provider had failed to investigate or put a plan in place to safeguard this resident in line with their own policy.

Inspectors reviewed the arrangements for the detection and reporting of abuse within the centre, including a review of the accident and incident records maintained in the centre. Inspectors found that there were a lot of reports of unexplained bruising. While these had been recorded on incident records, the provider had failed to ensure that that these had been consistently investigated. In addition, inspectors found that there was no surveillance of this information such as a thematic analysis in order to alert the provider of any common factors in the nature and development of the bruising.

Inspectors found that the provider's overall management and oversight of safeguarding plans was inadequate. Safeguarding plans are an important part of identifying and responding to risks to the safety of residents, and are required as part of the national safeguarding policy. Inspectors met with the designated officer for the centre who advised that there were 22 active safeguarding plans for residents in the centre. Inspectors met with the person in charge who advised that there were only 13 active safeguarding plans in place.

Inspectors found that there was inadequate oversight of safeguarding issues and safeguarding investigations. The provider was requested to give the inspectors details of the number of incidents reported, those leading to an investigation and those where a safeguarding plan was now in place where a member of staff was named in the allegation. The designated officer stated that this information was not readily available and would require a significant piece of work to produce it. The provider was unable to produce this information during the inspection and was requested to provide this information following the inspection.

Inspectors spoke with staff on duty and although inspectors found that staff had an understanding of what constituted abuse, they were not consistently familiar with the residents' safeguarding plans and had not all received safeguarding of vulnerable adults training.

Inspectors found that the provider had failed to ensure that staff had the required knowledge and skills to support residents with behaviour that challenges. Residents' behaviour support plans were not being consistently reviewed following incidents. In addition, different behaviour support interventions were contained across a number of different documents, leading to a level of confusion for staff. In some bungalows inspectors found that some staff had limited knowledge of the residents, their risks and their behaviour support plans. For example, in one bungalow a resident with very specific behaviour support requirements was being supported by two members of staff, one of which had started with the organisation five days previously, the other on the day of the inspection. Neither member of staff was aware of the active behaviour support plans in place to support the resident. These staff confirmed to inspectors that they did not know what they would do in the event of the resident exhibiting behaviour that challenges.

Inspectors reviewed the use of restrictive practices in the centre. Since the last inspection the provider had reviewed the medication management arrangements that were used to support residents with behaviour that challenges. Inspectors found that there were now up-to-date administration protocols in place to guide and support staff. In addition, all restrictive practices in place at the centre were being recorded with a clear rationale for their use. However, inspectors found that some residents' were unable to have free movement and access to such key areas of the bungalow as toilets and the kitchen due to the restrictive measures that were in place for one resident. While inspectors recognised that the measures were put in place to keep that resident safe, the person in charge had not adequately considered the impact that one resident's restrictions was having on their peers.

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

Findings:
Inspectors found that notifications required by the Chief Inspector were not submitted within the required timeframes.

Inspectors found that the person in charge had ensured that quarterly notifications were submitted which included the use of chemical restraint and non-serious injuries to residents. However, inspectors found that notifications which related to allegations, suspected or confirmed, of abuse had not been consistently sent within the required timeframes.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
The inspectors found that although some residents had increased access to social activities these did not reflect their interests and personal goals.

Inspectors reviewed residents' activity records and found that since the previous inspection, some residents now had increased opportunities for social activities in the

local community. However, inspectors found that activities offered did not consistently reflect resident's personal goals, interests and weekly activity schedules.

In addition, inspectors were told by staff that residents' access to activities in the local community was at times affected by the availability of suitably qualified staff and accessible vehicles. Inspectors were further told that the centre had engaged two activity coordinators to further promote social activities for residents; however, due to staff absences only one coordinator was available.

Inspector further found that although residents accessed social activities in the local community, no assessments had been completed to support residents to participate in education, training or employment opportunities.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Inspectors found that residents' health care and nutritional needs were not being met and significant improvement was required. In addition, inspectors reviewed the four actions from the last inspection and found that they had not been adequately addressed.

The centre's organisational risk register identified that there was no General Practitioner (GP) services available every fourth week which the provider had identified as putting residents health at risk. This had been given the highest risk rating on the provider's risk register. The person in charge confirmed that the availability of GP services was impacting on residents who required medical treatment and on occasions had lead to residents having to be transferred to the local general hospital or wait until the out of hours GP service was available for medical treatment.

Inspectors reviewed residents' health care plans and found that there was insufficient assessment and coordination in the response to the needs of the residents and the delivery of care. For example, Inspectors saw that two residents with specific eating, drinking and swallowing needs had recently eaten unsuitable foods putting them at risk of choking. Inspectors sampled healthcare records and found that following incidents of

concern, referrals and follow up appointments had not been made to speech and language therapists and dietician services. Residents' family members also told inspectors that they had concerns that staff were not consistently addressing their relatives' healthcare needs.

Inspectors found a number of residents were being treated for pressure wounds and although preventative measures were in place for some residents, these measures were not consistently being implemented. For example, inspectors observed one resident with a high risk of pressure wounds sitting on a towel on their wheelchair, the resident told inspectors that their wheelchair cushion was uncomfortable and they couldn't use it. However, no follow up actions or consultation with the prescribing healthcare professional had been taken by the person in charge. Inspectors also spoke to staff at the centre and found that they were not knowledgeable about residents' healthcare needs as reflected in their personal plans.

Inspectors found one incident where a resident had not received a planned surgical procedure in line with their urgent healthcare needs, as staff had not ensured that medication required to relax the resident prior to their hospital admission was administered as instructed by the GP. As a result, the procedure had to be cancelled and postponed for over two months, which prolonged the risks of choking and discomfort for the resident.

During the last inspection, inspectors found that there was insufficient access to dietitian services in the centre. The provider advised HIQA in their action plan response that a part-time dietitian service was available for all residents on a weekly basis. However, access to the dietitian was inconsistent and there were several incidents where residents did not have nutritional assessments reviewed appropriately. Furthermore, there was a lack of timeliness by staff in responding to healthcare needs. For example, some residents with long standing weight issues had only recently been referred to the dietitian.

Inspectors reviewed the protocols in place around the use of therapeutic medical equipment. Inspectors found that the person in charge had ensured that protocols were in place for the correct use of nebulisers, oxygen and catheters.

On the last inspection, inspectors found that residents' meals were provided by a centralised kitchen on the campus, which had resulted in a limited choice for residents. The provider had stated after the last inspection that they had ensured that residents now had access to a choice of snacks and alternative meals as they wished. However, inspectors found that food choices had not improved for residents with main meals continuing to be delivered from the central kitchen. In addition, inspectors found that there was limited food stocks available to offer residents an alternative choice, if they did not like the meals provided. Furthermore, inspectors found that dry foods stocks were ordered on a weekly basis from the centralised kitchen; however, these choices remained limited. In addition, staff did not have access to funds to purchase alternative foods specific to residents' likes and preferences.

Judgment:

Non Compliant - Major

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
Inspectors found that there were adequate arrangements for the ordering, prescribing and storage of medication in the centre; however, improvements were required to the administration of medication.

At the last inspection it was found that there was a lack of trained staff to administer medication during the day and in an emergency in some houses in this centre. During this inspection, inspectors found that the provider had not addressed this issue. For example, inspectors found that some residents living in this centre had epilepsy and were prescribed, and occasionally required, emergency medication. However, the staff members supporting the residents on the days of inspection were not trained in the administration of this medication. In addition, training records reviewed did not show whether any of the centre's staff had been trained in the administration of emergency medication.

Inspectors found that protocols regarding the administration of other p.r.n. (as required) medication were now in place.

Inspectors found that the centre had been traditionally nurse led; however, was currently moving towards a social care model. This transition had lead to some bungalows being staffed by social care workers, and the person in charge had not ensured that adequate numbers of staff in these bungalows had received training in the safe administration of medication. Consequently, inspectors found that nurses rostered on duty had to move between a numbers of bungalows in order to administer medication. Inspectors were told that this practice lead to residents not getting their medication at the correct times as prescribed.

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 centre's statement of purpose did not reflect the service and facilities provided and did not meet the requirements of Schedule 1 of the regulations.

The previous inspection had found that the centre's statement of purpose did not reflect the service provided. Since then, the provider had changed the function of parts of the centre and were offering a day service in one bungalow. Inspectors reviewed the centre's current statement of purpose during this inspection and found that it again did not reflect the services provided and all of the requirements of the regulations.

Inspectors found that although the statement of purpose included a floor plan for each bungalow, these had not been updated to reflect changes in rooms' primary function since the last inspection. In addition, the dimensions and function of each room was not included.

Inspectors found that the provider had made changes to the service and had not informed the Health Information and Quality Authority of changes to the centre's facilities, as required by the regulations.

Inspectors were further made aware by staff that the respite bungalow was used to provide day services for residents, which was not reflected in the statement of purpose.

Furthermore, the statement of purpose did not include information on arrangements to support residents to access education, training and employment opportunities.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that the provider's governance and management arrangements failed to ensure safe, and good quality services to residents.

Inspectors found that actions that the provider had said they would take arising from the last inspection had not been completed. Inspectors also found that where actions had been taken that, in some cases, they had failed to effectively address the issues that had been identified. For example, actions relating to maintenance works, staff training and fire safety improvements had not occurred which resulted in continued non-compliance at the centre. While the provider had introduced an annual schedule of audits covering such as, infection control, personal plans and staff training - these were either not completed or had not been actioned within the timescale identified by the provider.

Inspectors found that the provider's governance of safeguarding procedures at the centre had not ensured that concerns were consistently investigated and that residents felt safe at the centre and were protected from the risk of abuse. Furthermore, knowledge on the number of safeguarding concerns differed between the provider's designated safeguarding officer and the centre's person in charge.

Inspectors met with the provider representative and found that they were unable to demonstrate effective oversight of the services provided, including up-to-date knowledge on the number and nature of safeguarding concerns in the centre, the assessment, monitoring and regular review of risk, the on-going maintenance schedules and high priority areas for resolution.

Inspectors found that the provider's risk management systems had not ensured effective monitoring and completion of maintenance works at the centre such as faulty fire equipment, kitchen renovations and general building redecoration. Failure of the provider to address fire safety issues in the centre resulted in two immediate actions being issued during the inspection.

Inspectors further found that governance and management arrangement had not ensured that residents were supported by either consistent or suitably qualified staff. Inspectors found that staff had not received up-to-date training in-line with the provider's policies and although recruitment had occurred at the centre there was a continued reliance on temporary workers to achieve staff support arrangements.

Inspectors found that the provider had completed an annual review of the care and support provided at the centre and had undertaken six monthly unannounced visits. However, the provider had failed to assess the effectiveness of all systems in place at

the centre. Furthermore, inspectors found that actions identified in the providers own reports not been addressed within agreed timeframes such as training deficits, maintenance issues, falls analysis and the completion of audits.

Judgment:
Non Compliant - Major

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 person in charge had not been absent from the centre for over 28 days.

Inspectors found that there had been no occasions when the person in charge had been absent from the centre for over 28 days. In addition, inspectors found that arrangements were in place in the event of the person in charge's absence which reflected staff knowledge.

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:
Since the last inspection the provider had reviewed the transport policy to enable more staff to drive the centre's transport. However, the provider had not ensured that residents who used wheelchairs had sufficient access to transport, due to only one

wheelchair accessible vehicle being available to a large number of residents who required that resource.

In addition, residents were not being supported to receive their care in line with the statement of purpose, due to poor allocation of resources. Inspectors found that residents ability to participate in activities was limited by insufficient numbers of staff with the required training in medication administration. This meant that community activities were not occurring as planned, and residents had to spend a significant amount of time in and around the centre without meaningful activity or past times.

Inspectors found that a resident who had requested a motorised wheelchair in order to increase their independence had not been provided with this, and that despite requesting this, an assessment had not been arranged to determine the suitability of a wheelchair.

Following the previous inspection, the provider planned to address deficits in support for residents by appointing two activity coordinators. However, one of these staff has been on long term leave from the service. The provider has failed to introduce a contingency arrangement to ensure that residents were not prevented from achieving their goals and wishes as a result of this.

At night time inspectors found that residents did not have consistent access to nurse cover in the centre to meet their emergency health care needs should these be required.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found that the provider had not ensured that staffing arrangements met residents' assessed needs.

The previous inspection had found that some staff had not received up-to-date training

and there was a lack of continuity of care for residents, due to a reliance on temporary workers. Inspectors found that staff familiar to residents were being moved to other parts of the campus when there were staff shortages. This had also been an issue at the previous inspection.

Inspectors found that while some recruitment had occurred only three out of the 17 vacant posts had been recruited to, leading to a continued reliance on agency staff to meet the required staffing levels at the centre. Although rosters showed that efforts were being made to use the same temporary staff, this was not consistently the case. For example, over a 14-day period in one bungalow, temporary workers were used each day, with ten days out of 14 showing that two out of the three staff on duty were temporary.

Inspectors further found that where residents required access to nursing care at night this was not consistently available, due to a night nurse supervisor vacancy at the centre. Furthermore, in the event of a resident required unexpected nursing support during the night, it would mean that staffing for residents in other bungalows would be affected. Inspectors were told that the provider had agreed additional staffing to enable a nurse to be released, when required, without impacting on overall staffing levels in the centre. However, the person in charge had only rostered this resource on four occasions since the last inspection.

Inspectors reviewed training records and found that the person in charge had not ensured that staff had received up-to-date training in line with both the provider's policies and residents' needs. Inspectors reviewed records and found that :

10% of staff did not have up-to-date fire safety training
12% of staff did not have up-to-date safeguarding of vulnerable adults training
14% of staff did not have up-to-date positive behaviour management training
31% of staff did not have up-to-date moving and handling training
96% of staff did not have hand hygiene training
98% of staff did not have infection control training
84% of staff had not received communication training
69% of staff had not received Children First training

Inspectors reviewed ten staff files including permanent, temporary and ancillary staff at the centre. Inspectors found staff files did not contain all documents required under Schedule 2 of the regulations to ensure that staff were suitable to work with vulnerable people including:
- Evidence of Garda vetting
- Two written references
- Full employment histories
- Contracts of employment
- Photographic identification
- Copies of qualifications

Judgment:
Non Compliant - Major

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

Theme:
Use of Information

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

Findings:
The inspectors found that the provider had not ensured that all records and documents required under the regulations were being maintained.

The inspectors reviewed policies and procedures available at the centre during the inspection. The inspectors found that overall the provider had ensured that policies were up-to-date in accordance with Schedule 5 of the regulations. However, although the provider had an up-to-date policy on garda vetting of staff, inspectors found that the provider's staff recruitment and selection policy was not available.

The inspectors found that the provider had an up-to-date directory of residents which reflected changes in the occupancy at the centre.

The inspectors however found that some records, required under Schedule 3, were not regularly updated. For example, inspectors found that records on the use of restrictive practices such as locked doors did not consistently record the duration they were in place.

Inspectors further found that records required under Schedule 4 were not consistently kept up-to-date or included all required information under the regulations. For example, inspectors found that written agreements did not include details of charges to be met by residents at the centre. Furthermore, inspectors found that although complaints were recorded, documentation reviewed did not consistently show that investigations had taken place or show the satisfaction of the complainant with an investigation's outcome.

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:

Stevan Orme
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004910
Date of Inspection:	16, 17 & 18 May 2017
Date of response:	11 August 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:
Inspectors found that many residents were not consulted in relation to decisions about the running of the centre and their daily activities.

1. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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

and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
a. Monthly Voices and Choices Group house meetings now take place in each Bungalow in Centre 2. If the actions coming from these meetings are not addressed then staff are to support the residents to make a formal complaint and escalate to PIC for investigation under the complaints policy. The resident will also be offered the support of the Independent Advocate as deemed necessary by the PIC CNM or SCL.
b. An Investigation took place to establish why a complaint made by a family was not reported to the PIC in relation to a hospital appointment. A procedure is put in place to support all future hospital visits for this person and this is part of his care plan. This procedure has been activated on two occasions since the inspection and has worked well.
c. The PIC will advise the management team within centre at the next team meeting (10 Aug 2017) to engage with an independent advocate through the National Advocacy Service to ensure that the voice of the resident continues to be heard within the Service. Also to ensure all agency staff are familiar with the induction folder which contains the complaints process.

Proposed Timescale: 28/08/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents had limited opportunities to participate in activities in accordance with their interests, capabilities and developmental needs. For example, activities did not consistently reflect personal plans sampled.

2. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
a. A review of staffing complement and skill mix across the service took place on 28/07/2017. Which identifies the staffing need within Centre 2, so that community connections can be re-established.
b. Each person will be supported by their keyworker to complete an Education, Training and Employment Assessment by 31/10/2017 to capture their individual attainments and to identify individual interests. The outcome on this assessment will be part of the persons personal plan.
c. All goals identified from PCP will have a named person (Key worker/Link worker) responsible for enacting an action by 31/10/2017
d. One resident has been supported in trailing a motorised wheelchair as identified in PCP; the Occupational therapist is supporting with this trial and will assess the suitability of this powered wheelchair by 01/09/2019. A decision and a plan will be in place with input from the resident.

Proposed Timescale: 30/11/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider did not ensure that each resident was provided with care and support in accordance with their assessed needs and wishes.

3. Action Required:
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:
a. All goals identified from PCP will have a named person (Key worker/Link worker) responsible for enacting it and a time frame.
b. The HR department have been working intensively with the management of the centre to address and reduce all attendance management issues. To ensure that the required numbers of staff are available to meet the assessed needs of the individuals requiring support on a daily basis.
c. Community Connectors Team are being re-established to provide meaningful activities to meet the assessed social care needs of residents. Where there has been an assessed one to one staff support requirement, will be provided with support from Community Connectors.

Proposed Timescale: 31/12/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that residents and family complaints were not always investigated and in some cases that were investigated, residents and family members were not informed of the outcomes and the complaint. Furthermore, inspectors found that there was no record of whether the complainantant was satisfied with the outcome of the complaint.

4. Action Required:
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

Please state the actions you have taken or are planning to take:
a. All complaints or concerns from individuals, verbal or otherwise during or independent of meetings regarding any aspect of service provision will include an investigation and involvement of individuals in the process and evidence of their level of satisfaction or otherwise with the outcome. This will be dealt with promptly and within

the timeframes as laid out in the policy.
b. Staff will receive induction to the complaints policy in each area by the CNM/SCL and the PIC will develop a SOP on the Complaints Policy which will be circulated to staff teams. This SOP will also form part of induction pack that is given to every new staff member to read on Induction.
c. An induction folder to support staff will be updated by PIC and maintained in all Bungalows. All staff are to read and sign the complaints policy. The CNM 2 will ensure that complaints will be a standard item on the agenda at local team meetings
d. Families will be encouraged to respond to their level of satisfaction on the outcome of a complaint investigation. An audit of complaints will continue to takes place monthly by the PIC.
e. The PIC and SCL had developed an informal verbal complaints process for to support one resident. This process will have oversite from the MDT and Studio 3 team to ensure all concerns are correlated to BSP SGP and Communication Plan.

Proposed Timescale: 30/09/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that not all staff had received communication training in line with residents needs, for example such as sign language.

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

Please state the actions you have taken or are planning to take:
a. SALT and PIC will undertake an audit on the resident's communication passport to ensure that the recommended system for communication is in place to support the resident with communication. This audit will be completed by the 31/09/2017.
b. Staff training in communication is mandatory and a schedule of training dates will be made available by SaLT by 01/09/2017.

Proposed Timescale: 30/09/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents had not received assistive technology assessments to further support their communication needs.

6. Action Required:

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

Please state the actions you have taken or are planning to take:
a. The staff, SALT, occupational therapist, psychologist and management team have commenced looking at an assessment process for the assistive technology. This is being included as part of an access/communication/social assessment.
b. Staff are to be inducted to the residents communication Passport/Aids and the manual signing system that is place to help residents to understand what is happening their environment.
c. A training schedule will be put in place to ensure that all staff have are provided with training provided by SALTS.
d. PIC and SaLT are to undertake an audit to establish staffs level of understanding in relation to communication passports. A review of an audit tool is currently underway by PIC and SaLT. Audit to be completed by 25/08/2017

Proposed Timescale: 31/12/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that written agreements did not include the total fee and any additional charges to be met by the resident.

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

Please state the actions you have taken or are planning to take:
a. A review of the service agreements has taken place, and updated agreements were reissued to residents and their families on the 17th July 2017 (9 out of 16 families have returned same to centre 2 by 10/08/2017
b. Key workers are to communicate with families to ensure that they are satisfied with the agreement and encourage families to return signed copied to the service by the 30/08/2017. PIC will maintain a record of agreement retuned and follow-up where appropriate.

Proposed Timescale: 31/08/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that residents did not have access to social activities in line with their personal plans.

8. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
a. PIC is conducting a staffing skill mix review to include an additional community connector. This will be completed by 18/08/2017.
b. Residents and their representative will be consistently supported to be involved in PCP planning meetings, by way of a written invitation from the Key worker.
c. Safe management of medication training continued to a priority to ensure that sufficient numbers of trained staff are medication management training to support social outings
d. A transport assessment has taking place for Centre 2 and one additional transport has been rented for one resident since inspection. A costing has been sought by the DOS to adopt two existing mini buses to be wheelchair accessible. A request has been sent to management to retain a further car when one resident moves out to an external provider on 18/08/2017.
e. Personal Plans are to identify the resident's social preferences and the named keyworker is to ensure these preferences are actions.

Proposed Timescale: 30/11/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Minutes of annual review meetings did not consistently demonstrate that the residents or their representatives were involved in the review meeting.

9. 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:
a. There is a planned schedule of annual reviews now in place for the year 2017/2018 in Centre 2, and is available in Annual Planning and Review Folder with CNM2
14 out of 16 annual reviews are now completed for 2017. Residents and their representative are formally invited by the key worker to attend the Annual review. Minutes of annual review meetings will reflect that the residents or their representatives were involved in the review meeting.

Proposed Timescale: 30/09/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not available to all residents in an accessible version.

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

Please state the actions you have taken or are planning to take:
Personal plans are to be made available to all residents in an accessible user friendly version, with support from SALT and the document review group. CNM and SCL are to ensure that these plans are in place by 30/12/2017

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:
Review meetings did not assess the effectiveness of all aspects of residents' personal plans.

11. 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:
a. An evaluation tool to measure the effectiveness of Personal Plans is to be drafted by the PIC by 01/09/2017
b. While interim transition plans are in place the transition team will develop final transfer plans to include details of when and where the resident would transfer to within community. This will take place on an ongoing basis as more information becomes available during the transition process.
c. The key worker will ensure that all future review meeting will assess the effectiveness of the personal plan by identifying outcomes which have been achieved or not achieved.

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:
Inspectors found that not all residents' personal plans were subject to an annual review.

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

Please state the actions you have taken or are planning to take:
a. A schedule of Annual reviews is now in place whereby all residents dates for reviews is planned in advance, and that reviews take place in a timely manner. This is overseen by the PIC and CNM2/Team Leader
b. All residents have a key worker and will continue to have a key worker during transition.
c. The PIC will ensure that if any keyworker leaves the service a new key worker will be identified within one week.

Proposed Timescale: 03/08/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that residents' personal goals did not consistently include named staff supports and timeframes for achievement.

13. 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:
a) All residents have a key worker and will continue to have a key worker during transition.
b) Minutes of meetings will reflect the name of the individual responsible for supporting the resident to achieve a goal and all staff have responsibility in supporting residents to achieve a Goal with oversight from the key worker.
c) The PIC and CNM2 will continue to monitor Personal Plans to ensure goals are achieved in a timely manner by discussing Personal Plans at team meetings.

Proposed Timescale: 31/08/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that transitional plans did not include timeframes and information on alternative accommodation.

14. Action Required:
Under Regulation 25 (4) (d) you are required to: Ensure the discharge of residents from the designated centre is discussed, planned for and agreed with residents and, where appropriate, with residents' representatives.

Please state the actions you have taken or are planning to take:
a. While there are interim transition plans in place, the transition team are to update transition plans as more information becomes available. Transition plans will be revised and amended by the transition team to identify the services and supports that are required by each resident. and these will be available in the Residents Personal File. The PIC and CNM2 will continue to monitor time

Proposed Timescale: 30/09/2017

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 provider had not ensured that repairs and maintenance to the centre's bungalows were addressed in a timely manner. Inspectors observed that

- Bungalows had not been recently painted
- Ceiling tiles were stained and discoloured
- Fire evacuation routes were not suitably surfaced
- Guttering was damaged

15. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
A maintenance audit of the Centre has been completed and a planned maintenance programme for the period 01st July 2017 – 31st December 2017 has been instigated. The programme includes upgrades under a number of headings to include: painting, footpaths / egress, external lighting upgrades, floor / surface upgrades, external cleaning programme, suspended ceiling upgrade, bathroom upgrades, kitchen upgrades.

a. A maintenance action plan is in place for centre 2 and is reviewed by senor management ever two weeks.

b. The environment is monitoring daily both external emergency lighting and pathway egress and a safety check is in place,
c. Some update has taken place in the Respite environment to provide privacy where there is a glass panel in a bed room.
d. Further action is to put door handles on all doors in the respite accommodation and install a small kitchenette in this area.
e. The PIC and CNM2 is to include a cleaning schedule as part of the daily routine in each location within Centre 2 by the 30/07/2017

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider did not ensure that equipment used by residents was well maintained and in good working order.

16. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
A maintenance audit of Centre 2 has been completed and a planned maintenance programme is in place.
a. The programme includes upgrades under a number of headings to include: painting, footpaths / egress, external lighting upgrades, floor / surface upgrades, external cleaning programme, suspended ceiling upgrade, bathroom upgrades, kitchen upgrades is to be maintained and monitored monthly by the PIC and CNM2
b. The PIC and CNM2 is to include a cleaning of equipment as part of the daily routine in each location within Centre 2 by the 30/08/2017 and equipment maintenance will be a stand agenda Item at local team meetings.
c. A log of all maintenance requests will be maintained at Bungalow level in a hardback copy book with expected completion dates.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that the centre's building reflected residents' needs. Inspectors observed the following :

- Not all residents had access to laundry facilities in their bungalows

- Not all residents had access to kitchen facilities
- Not all residents had access to a sufficient number of suitable bathroom facilities

17. 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 action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider's risk management policy did not contain the measures to place to identify, measure and control risk at the centre.

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

Please state the actions you have taken or are planning to take:
External lights were replaced, will be monitored and any faults reported as part of the Fire register checks .A new section of footpath has been installed as part of on-going maintenance schedule. All egress pathways are to be checked on a daily basis to ensure safe exit to assembly point.
a. The service will use the HSE Integrated Risk Management Policy. In addition we are developing a Standard Operational Procedure and staff will be inducted to risk management. PIC is to ensure that this procedure is available within the Induction Folder to support staff with risk management.
b. The HSE has committed finance to a program of fire compliance structural works which is currently underway and on target see attached Gantt chart. Incorporated into this plan is a schedule of painting, decorating and suspended ceiling upgrade which will enhance the living space. Individuals will be consulted and supported to enable them to make choices on the personalisation of their living areas.
c. A new Quality and Patient Safety Manager has been appointed to the CHO2 area to oversee risk. Part of his remit will be to oversee risk management in Aras Attracta.
d. A new risk management pathway will be a priority for this Manager. Integral to that is a review of the risk policy within Aras Attracta. Part of the review of the risk management policy will be hazard identification, assessment of risk, control measures and education for all staff.

e. Fire and evacuation training ongoing and scheduled for the Centre. A New Falls management pathway is in place and all staff will be indicted to same by PIC Physio Therapist and CNMs.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider did not ensure that there were robust arrangements in place at the centre to assess, manage and review ongoing risks. For example, the high risks of unwitnessed falls and incidents of choking in the centre.

19. 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 action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that residents were protected from healthcare associated infections, by adopting appropriate procedures for managing infection control risks in the centre, and by ensuring all staff were made aware of the risks by providing training in infection control procedures for all staff.

20. 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:
a. The risk management policy is currently under review with input from the Quality and Safety Manager and will be amended to reflect the controls required to reduce the level of risk.
b. A risk assessment pertaining to MRSA is complete. Advice and support was sought from the Occupational Health Department Galway and measures were put in place.

c. Infection Control policy in place with hand hygiene training schedules to be rolled out to all staff across the service. One staff member has been trained as Hand Hygiene Instructor to support this process. A training record on infection control will be maintained and reviewed by the PIC and CNM on a monthly basis. Training is a standard agenda Item at local and senor management meetings.
d. All grades of staff including external contractors onsite are advised to adhere to the national policy and guidelines on Infection Control.

Proposed Timescale: 30/11/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put adequate arrangements in place to evacuate all people in the designated centre, in the event of a fire, and bring them to safe locations.

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

Please state the actions you have taken or are planning to take:
a. Fire Safety Assessment Report is complete and is available for viewing in the Centre. We are working with Estate Department to progress required works. Timelines to be determined and will advise Authority once confirmed.
b. 100% of staff in centre 2 have Mandatory Fire safety training completed. Fire training remains an ongoing and will continue to be facilitated by an external Fire Company.
c. A panic alert and pager system is in place, they are checked on a daily basis to ensure that they are in working order and will alert staff in the event of a fire. Monitoring of daily fire checks are signed off by staff locally as part of daily routine.
d. The health and safety folder in each home includes a fire register and daily checks are in place. This folder is audited by the CNM and PIC on a Monthly basis. Health and Safety is a standard Agenda Item at local and senor management meetings. to maintain safety in relation to fire.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to make adequate arrangements for the containment of fire.

22. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
a. Fire Safety Assessment Report is complete and is available for viewing in the Centre. We are working with Estate Department to progress required works. Timelines to be determined and will advise Authority once confirmed.
b. 100% of staff in centre 2 have Mandatory Fire safety training completed. Fire training remains an ongoing and will continue to be facilitated by an external Fire Company.
c. All exits are being used to egress the Bungalow, lighting has been upgraded and footpaths are included in the maintenance plan and A panic alert and pager system is in place, which is checked regularly and will alert staff in the event of a fire. An audit of staff compliance with this equipment will continue.
d. A central log of all agreed works and a flowchart of the quotations, approvals and completion dates is held in the Maintenance Office. The health and safety folder in each home includes a fire register and daily checks are in place to maintain safety in relation to fire.
e. The HSE has committed finance to a program of fire compliance structural works which is currently underway and on target see attached Gantt chart. Incorporated into this plan is a schedule of painting, decorating and suspended ceiling upgrade which will enhance the living space. Individuals will be consulted and supported to enable them to make choices on the personalisation of their living areas.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff had not received fire safety training and were not familiar with the fire evacuation procedures in the centre.

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

Please state the actions you have taken or are planning to take:
a. 100% of staff in centre 2 now has Mandatory Fire safety training completed.
b. Fire training remains an ongoing and will continue to be facilitated by an external Fire Company. A Fire training log is maintained at the centre and a fire training schedule is in place. The PIC and CNM will continue to monitor training. Training is a standard Agenda item at local and senior management meetings.

Proposed Timescale: 22/07/2017

Theme: Effective Services

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

the following respect:
The provider failed to ensure that there was adequate means of escape from the premise including emergency lighting.

24. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
a. All doors are used as a means to egress from the Bungalows in centre 2, and A checklist has been put in place to ensure that the pathway and lighting is in good working order.
b. Routine Checklist are to be developed by the PIC and CNM for all Bungalows and maintenance checks including Lighting and pathways to be part to the daily checks. This action is to be completed by 18/08/2017 by PIC
c. The HSE has committed finance to a program of fire compliance structural works which is currently underway and on target see attached Gantt chart.

Proposed Timescale: 31/12/2017

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:
Inspectors found that not all staff had up-to-date knowledge on how to support residents to manage behaviour that challenges. Furthermore, behaviour support plans had not been consistently reviewed following incidents of concern.

25. 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:
The action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that not all staff had received appropriate positive behaviour

management training.

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

Please state the actions you have taken or are planning to take:
The service now has three staff who are trained locally as train the trainers in Studio 111 to provide training. The training includes the management of behaviour that challenge including de-escalation and intervention techniques.

A schedule of training is in place to ensure that all staff have completed this mandatory training within the timeframe. All mandatory training records are reviewed on a monthly basis through the local QPS Committee, to ensure that targets are being met to ensure that all staff in the service are trained.
a. The PIC, CNM2 and SCL is to continue to monitor training records to ensure that all staff are trained in the management of behaviour, including de-escalation and intervention techniques in line with Studio 3 training.

Proposed Timescale: 30/09/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to assess the impact of environmental restrictions on other residents.

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

Please state the actions you have taken or are planning to take:
a. The PIC and CNM will continue to strive to maintain core staffing in each bungalow. Team leader now in Bungalow 10 who has a responsibility for rostering and maintaining core staffing. CNM 2 has a team lead responsibility for two bungalows. This action will be in place by 21/08/2017
b. Environmental and physical restrictive practices are been recorded in a restrictive practice diary and a record of chemical restrictive practice used is maintained on each resident's IMPAR book and reported on NF39 quarterly returns. The CNS in behaviour carries out a bi-annual audit on all restrictive practices and report's findings to the PIC
c. One door in B6 that was been locked to provide an individual service in now been recorded in the restrictive practice diary and reported on NF39 quarterly returns.

Proposed Timescale: 30/09/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that not all staff had received safeguarding of vulnerable adults training.

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

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that residents were protected from all forms of abuse.

29. 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:
a. The PIC and Safeguarding Officer responded to a safeguarding issued in the centre by putting a core team in place supported by a acting Social Care Leader.
b. The use of a diary for recording allegation that a resident was making has ceased and an verbal informal complaints protocol is now in place which escalates complaints on the resident request. This protocol is monitored by the PIC and MDT on a monthly basis.
c. A protocol is in place to support staff to actively listen to concerns and provide emotional support to the resident. Counselling support has commenced for this person.
d. A safeguarding plan is in place and regular communication and evaluation meeting takes place with the designated officer and the resident to track progress.
e. All reports of unexplained bruising is investigated by the safeguarding officer DO and thematic analysis common factors are identified and as far as possible addressed through care and support plans and reviewed at MDT meetings.
f. One resident with complex support needs has now transferred to an external Service Provider in community and there are plans in place for another resident to transfer on the 18/08/2017

Proposed Timescale: 30/06/2017

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:
Notifications which related to allegations , suspected or confirmed of abuse were not sent to the Chief Inspector within the regulatory timeframes.

30. 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:
CNM2 to be supported in submitting notifications of events in the absence of PIC

Proposed Timescale: 31/05/2017

Outcome 10. General Welfare and Development

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents had not been assessed or supported to participate in education, training and employment opportunities.

31. Action Required:
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:
Formal and informal assessments will be used to identify residents identify education training development employment. Key worker will discuss with the resident their preferred activity and the appropriate MDT referral will be made as deemed suitable, these preference will also be part of the persons PCP.
a. PIC and CNM/ SCL will put in place Smart Goals will be identified to help resident achieve these plans in a timely manner.

Proposed Timescale: 31/12/2017

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that residents were not consistently supported to access activities which reflected their personal goals and interests.

32. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
a. PIC is review staffing complement and skill mix to establish how resources can be allocated to support to re-established support for community connection. Nine residents need the support of a community connection to build links within community. The PIC will put forward a business case to the HSE for additional resources to support this action by 20/08/2017 .
b. An assessed area within the PCP is to reflect the educational, training, and employment opportunities for residents.
c. The format for information gathering around PCP is currently under review by the documentation review group.
d. One additional transport is now in pace for one resident.
e. A request has been submitted for an additional wheelchair transport either to rent or buy.
f. Community Connectors Team are being re-establish to provide meaningful activities to meet the assessed social care needs of residents. Where there has been an assessed one to one staff support requirement, this is being provided on a consistent basis and reviewed monthly by the centre manager.

Proposed Timescale: 30/09/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure comprehensive assessments and reviews of the residents' health care needs having regard to their personal plan.

The provider also failed to ensure that arrangements were in place to facilitate a resident having a surgical treatment as recommended by their general practitioner and hospital consultant and in line with their health care plan.

33. 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:
Residents currently have their yearly assessment completed including social and medical assessments. Care plans are developed in line with the assessment of need to include training, development and education and they are reviewed three monthly.
a. A support plan with the appropriate skill set has been put in place where residents need individualised supports to access hospital appointments and medical procedures.
b. Annual reviews for each resident will take place in line with the schedule of Annual PCP reviews now in place.
c. Care plans are modified to reflect the nutritional needs of the individual resident. Referrals are made to the dietician where a concern is noted
d. Residents and their families are directly involved in the review meetings.
e. Input from Occupational Therapist will be sought to support and identify opportunities in developing skills towards independence and develop a support plan
f. An audit of the effectiveness of Personal Profiles, and required changes to this documentation, has commenced and will be ongoing by management. Audits will initially be quarterly and annually thereafter.

Proposed Timescale: 30/11/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not supported to buy, prepare and cook their own meals in the centre, if they so wished.

34. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
a) All residents will continue be supported to have access to meals, refreshments and snacks according to their will and preference and within the guidance of the dietarian.
b) Residents will be supported to compile a snacks preference and will be supported to be offered access to same at regular intervals throughout the day.
c) Resident's likes and dislikes are considered and second options of meals are offered in the case where residents choose not to have that particular meal on that particular day.
d) A revised governance arrangement will be put in place in the absence of team leaders whereby the CNM2 will have a responsibility to monitor and review practices in individual locations.

Proposed Timescale: 31/12/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
The person in charge did not ensure that all residents' had access to refreshments and snacks at reasonable times or as required.

35. Action Required:
Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

Please state the actions you have taken or are planning to take:
a) All residents will continue be supported to have access to meals, refreshments and snacks according to their will and preference and within the guidance of the dietarian.
b) Residents will be supported to compile a snacks preference and will be supported to be offered access to same at regular intervals throughout the day.
c) Resident's likes and dislikes are considered and second options of meals are offered in the case where residents choose not to have that particular meal on that particular day.
d) A revised governance arrangement in place in the absence of team leaders whereby the CNM2 will have a responsibility to monitor and review practices in individual locations.

Proposed Timescale: 30/06/2017

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 person in charge did not put appropriate practices in place to ensure residents received their medication in a timely manner and as prescribed.

The person in charge had failed to ensure that staff had the required skills to administer emergency medication in the centre.

36. 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:
a. Night Supervisor in place to support with administration of night time medication.
b. SAMS training ongoing. Dates scheduled for September 2017.
c. Audits of all PRN Protocols are carried out by the CNS to ensure that the PRN protocols contain the maximum dosage to be administered in 24hours is been adhered.
d. Based on this audit a report will be produced in August 2017 to improve the efficiency of the process. All medication errors will be reported to through incident reporting protocol and will be investigated as deemed appropriate.

e. In September 2017 CNS in Behaviours that Challenge is going to organise a small group of individuals (Staff Managers and CNS) to develop a clearer pathway for PRN usage both in terms of practices on the ground and key roles and responsibilities.
f. A skill mix review will be reviewed by 20/08/2017 to ensure the assessed needs of resident are met, i.e. the staff compliment is in place to meet the needs of the resident.

Proposed Timescale: 30/11/2017

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 centre's statement of purpose was not in accordance with Schedule 1 of the regulations.

37. 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:
a. The statement of purpose (SOP) is updated in line with Schedule 1 and will reflect all service provision and running of the Centre includes respite provision.
b. The SOP include educational training and employment opportunities to residents based on their will preference and assessed needs.
c. An updated SOP will be forwarded to the Authority by 11th August 2017

Proposed Timescale: 11/08/2017

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:
The centre's governance and management systems did not ensure the delivery of safe, and good quality services to residents.

38. 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 action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that actions from the provider's unannounced six monthly visits were not addressed within agreed timeframes.

39. 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 action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that the provider had not ensured that sufficient resources were available to meet the needs of residents.

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

Please state the actions you have taken or are planning to take:
The action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that arrangements were not in place to consistently provide night-time nursing staff to all residents.

41. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
a. Night supervisor is in place who ensure nursing needs are supported at night time.
b. A continues review of the nursing needs within the centre to ensure that the assessed skill mix is maintained by advising Agencies providing leave cover of the appropriate skills requirement.

Proposed Timescale: 30/06/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that the continuity of care in centre was impacted by a reliance on temporary workers to met residents" needs..

42. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
a. A staffing review has been completed and skill mix has been identified in order to effectively manage the Centre. This process requires the relocation of some grades of staff who will be transferred into the Centre.

b. The HR department have been working intensively with the management of the centre to address and reduce all attendance management issues. To ensure that the required numbers of staff are available to meet the assessed needs of the individuals requiring support on a daily basis.
c. An allocation of agency staff are available and utilised to cover planned and unplanned activities. There are active permanent staff recruitment panels. The centre is going through the transition process with regular reviews of staffing levels and skill mix

due to the decongregation plan for the Centre and the change to social care model of care.
d. Community Connectors Team are being re-establish to provide meaningful activities to meet the assessed social care needs of residents. Where there has been an assessed one to one staff support requirement, this is being provided on a consistent basis and reviewed monthly by the centre manager.

Proposed Timescale: 30/11/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff records did not contain all information required under Schedule 2 of the regulations.

43. 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:
a. A full review of all staff files has been completed in Centre 2 to ensure that these files now all meet the requirements specified in Schedule 2 of the regulations. The documents are now being prioritise for collection, for all staff directly employed by the HSE at the service and contracted agency, catering, cleaning and transport staff.

b. The Person in Charge with support from administration will complete bi-annual audits to ensure Schedule 2 information and documents remain in place for all staff.

Proposed Timescale: 30/09/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had not received training in-line with the provider's policies and residents' needs.

44. 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:
a. A training schedule will be put in place and all staff with receive training in line with the providers policies and residents assessed needs. (see attached training schedule).
b. The training records are discussed at senor management meetings and a monthly

audit of training is maintained.
c. Staff identified for training are identified continue to be in on the schedule of training.

Proposed Timescale: 30/09/2017

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 provider's policy on recruitment and selection was not available at the centre.

45. Action Required:
Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

Please state the actions you have taken or are planning to take:
a. Schedule 5 will include the policy on recruitment, selection and Garda vetting of staff.
b. This policy will be in the Schedule 5 folder in each Bungalow.
c. An Audit of the Schedule 5 folder will be include on the daily routine check list.

Proposed Timescale: 30/09/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that all records which related to residents were up-to-date as required under Schedule 3 of the regulations.

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

Please state the actions you have taken or are planning to take:
a. Restrictive practice diary is to continue to record physical and environmental restrictions.
b. Chemical restrictions are to be maintained on a chemical restriction log on the persons medication record book.
c. A daily routine check list is to be put in place in all Bungalow is centre 2 to support staff of the checks and required documentation and activities that takes place during the day.
d. The Induction folders is to be updated to include protocols around restrictive

practices in centre 2

Proposed Timescale: 30/09/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that all records required under Schedule 4 of the regulations were in place.

47. 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:
The action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale: