Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by The Irish Society for Autism
Centre ID:	OSV-0002000
Centre county:	Wexford
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Irish Society for Autism
Provider Nominee:	Tara Matthews
Lead inspector:	Ide Batan
Support inspector(s):	Caroline Connelly;
Type of inspection	Announced
Number of residents on the date of inspection:	5
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:
10 March 2015 10:45	10 March 2015 18:00
11 March 2015 09:15	11 March 2015 18:00
19 March 2015 09:40	19 March 2015 17:30

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

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

Summary of findings from this inspection

The centre consists of a large detached house in a remote location within a community setting. The inspectors were informed that the majority of the residents had autism and some had an intellectual disability also.

During this inspection inspectors met with some of the residents and staff members. They reviewed the premises, observed practices and reviewed documentation related to risk management, residents' records, accident and incident reports, medication management, staff supervision records logs, policies and procedures and a sample of staff files. Inspectors observed that all of the residents required a high level of

assistance and monitoring due to the complexity of their individual needs.

There was significant non compliance in relation to some fundamental and essential components of the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 including core aspects of governance which included, management of alleged allegations of abuse, staff supervision and reviewing quality and safety of care.

Overall the inspectors had significant concerns regarding the governance and management of the centre. There was a significant deficit in the management systems, the absence of a team leader within the house and the person in charge was not based in the centre The inspectors found that the person in charge, due to the extent of her remit, did not have the capacity to have oversight for three geographically diverse and high dependency designated centres.

The provider and person in charge were issued an immediate action plan on day 2 of inspection to:

Ensure that there was a clearly defined management structure that identifies the lines of authority and accountability, specific roles and details responsibilities for all areas of service provision

Ensure that management systems are in place to ensure that the service provided is safe, appropriate to residents needs, consistent and effectively monitored

The person in charge shall ensure that there is effective governance, operational management and administration of the designated centre.

The provider responded to the immediate action plan within the agreed timescale. Following the third day of inspection the provider contacted the Authority and informed the Authority that a staff member had been placed on administrative leave due to an alleged allegation of a abuse. However, inspectors had informed the provider and person in charge of these alleged allegations at the feedback meeting following inspection six days earlier on the 11 March 2014.

Present governance arrangements are not effective in ensuring safe outcomes for residents and do not give assurance that resident's health and social care needs are met. Inspectors were not assured that where a concern arises for the safety of an individual that the provider and person in charge take reasonable and proportionate interim measures to ensure the protection of all 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):
This was the centre's first inspection by the Authority.

Findings:
The inspectors reviewed resident's preferences, access to and participation in recreational activities. The inspectors spoke with staff in addition to making observations regarding resident's activation levels on the inspection and also reviewing the resident's progress notes. The inspectors found that residents had some level of activation however improvements were required to ensure that the activities were meaningful, frequent and in line with resident's preferences.

The programme of activities included art therapy, baking, gardening, feeding rabbits and hens, spins on the bus and short walks. Staff told the inspectors that some activities such as art, listening to music were facilitated in the cabin, which was a prefabricated building located in the garden to the rear of the main building. There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests, capacities and developmental needs. In addition the inspectors also found that outings were mostly group based activities; one to one activities and outings were infrequent. Overall, inspectors observed that activities were led by routine and resources not the resident and their support needs and wishes.

Inspectors observed and were told by staff that there was minimal integration with the local community. There was a resident who participated in a local fundraising walk within the community. Inspectors were told by a staff member that the resident had not participated this year as the key worker had not organised it.

Overall, inspectors were not satisfied that there was an effective complaints process in place to facilitate and support residents and/or their relatives to make a complaint.

There was a local complaints policy. The centre did maintain a complaints log to record complaints. However, inspectors observed that the process of recording the outcome of the complaints process or whether or not the complainant was satisfied with the outcome was very poor. The management of complaints was not adequate for the following reasons:

The complaints log did not record if the complainant was satisfied or not the complaint policy was not publicly displayed there was no second nominated person to respond and maintain complaint records as required under regulation.

Inspectors found there was no culture of advocacy within the centre. As outlined in further detail under Outcome 8 the provider and person in charge had been informed by inspectors on day two of inspection of an alleged incident of abuse. On day 3 of inspection which took place six days later the person in charge and provider told inspectors that they had spoken to all staff. However, the resident had not been consulted or supported and facilitated to access advocacy services in relation to the alleged allegation.

There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre, such as through residents meetings or resident/relative surveys. There was no evidence of any regular house meetings between residents and staff.

Inspectors noted that where possible residents retained control over their own possessions and that there was adequate space provided for storage of personal possessions. Inspectors reviewed the local arrangements' to ensure residents' financial affairs were safeguarded through appropriate practices and record keeping.

Residents required support to manage their money. Each resident had their own cash box which detailed monies signed in and out. Receipts were maintained for all purchases and running balances for each resident were checked and signed off on a daily basis. This was double checked every evening by staff and signed off as correct.

The provider outlined the system to manage resident's payments of the required fee as identified in the contracts of care. The provider was acting as pension agents for all of the residents as they said they had difficulty opening bank accounts for the residents. All residents either had post office accounts and or a credit union account statements and books were seen in the centre. Invoices were seen in relation to the cost of care for each resident per month in their financial records. Family members had identified on the questionnaires received by the Authority that they would like to receive a statement of their family members income and expenditure on a regular basis.

The provider said that statements were issues to residents. However, this statement only indicated the designated monthly service charge as observed by inspectors. It was also outlined in the contract of care that records of accounts would be made available to parents. However, some parents identified that they had never seen a statement of their sons' accounts. The records in relation to the pension agents were all kept in the head office in Dublin and the inspectors did not have access to same. The provider said that the accounts were audited on a regular basis by the accountant.

Each resident had their own bedroom decorated to suit their own tastes and interests.

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:
The inspector found that residents' communication needs were supported as evidenced in personal plans reviewed and through witnessed interactions. In the personal plans reviewed by the inspectors, residents' communication needs were outlined in a communication plan. The communication plans detailed their preferred method and abilities of communication. Where applicable residents used picture aids to assist them with their communication.

There was a policy on communication available. Residents had access to radios and televisions, the inspectors saw these in their bedrooms. An ipad was also available and inspectors saw residents playing games on it.

Staff told the inspectors they knew residents well, this assisted them in understanding their needs for example through gestures. The inspector found this to be reflective of witnessed interactions with residents.

Judgment:
Compliant

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

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 maintain relationships with family and friends. The centre had a visitor's policy; there were no restrictions placed on visits. The inspectors saw in daily notes and in personal plans evidenced of relatives visiting but also residents going home to see family at weekends. Residents had relationships for example with parents as observed by inspectors.

However, as outlined under Outcome 1 there was minimal integration with the local community.

Judgment:
Non Compliant - Major

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:
The organisation had a policy on admissions, discharge and transfer. The admissions policy did take into account of the need to protect residents from abuse by their peers.

Admissions were overseen by an admissions, discharge and transfer team. The provider said that most referrals came through the Health Service Executive (HSE). Inspectors saw that if a resident was transferred to hospital relevant information was made available to the service assuming responsibility for the resident. Staff told inspectors that they would stay with residents in the event of a hospital admission.

There were contracts of care in place some were signed by residents and parents others

were not. Detail regarding the services provided, the type of accommodation and the additional costs that may be incurred as part of their service was outlined.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
On this inspection the centre was in a process of introducing a revised personal planning system, which was at its infancy stages, however improvements were required to ensure the assessed needs of residents continued to be met.

The inspector reviewed a sample of resident's personal plans. The inspectors found that resident's needs were not sufficiently assessed and documented to ensure staff were providing safe and effective care in line with their assessed needs. From a sample of personal plans reviewed inspectors found where personal plans were in place, they were not comprehensive or sufficiently detailed to guide staff in providing consistent care.

Personal plans were also found not to be in place to meet the needs of some residents. Accidents and incidents documented at the centre and a recent notification received by the Authority was reviewed by inspectors. However on the first day of inspection there was no risk assessment completed in relation to the incident notified to the Authority for this resident. The person in charge completed a risk assessment when inspectors had brought this to her attention.

The inspectors read in resident’s progress notes, which included appointments they had attended such as general practitioner appointments. However these appointments were not updated in their personal plans as having occurred or what the actions/outcomes were. This required a review to ensure residents assessed needs and healthcare needs were accurately captured and recorded.

The personal plans did not set out in a formal manner the services and supports required to enhance the quality of life of residents, to realise their goals. The plans did not adequately address:

• education, lifelong learning and employment support services, where appropriate
• development, where appropriate, of a network of personal support
• transport services
the resident's wishes in relation to where he/she want to live and with whom
• the resident's wishes or aspirations around friendships, belonging and inclusion in the community
• the involvement of family or advocate.

The inspectors from a review of resident's personal plans were not assured that staff had sufficient knowledge on how to complete a personal plan and subsequent care plans. The inspectors were not assured staff had the appropriate skill set to meet the needs for all residents as further outlined in Outcome 17. One staff member told an inspector that the care plans were really of no benefit to residents.

Personal plans contained a significant amount of handwritten information that was in some instances unclear and posed as a risk if incorrectly interpreted by the reader. There was inadequate evidence of consultation with residents and their relatives in relation to the development of plans and there was inadequate evidence that plans were based on the aspirations and choices of residents.

There was evidence of very limited interdisciplinary team involvement in residents' care since 2013 such as speech and language therapy, dental, neurologist, ophthalmic, occupational therapy, General Practitioner (GP) and psychiatric services. There was no evidence of residents' involvement in developing and reviewing their personal plan.

From a selection of personal plans reviewed, inspectors noted a number of assessments had been conducted including capacity to self medicate, manage money, individualised risk assessments and activity assessments. However, from this review of residents' personal plans; inspectors formed the view that they were not adequate for the following reasons:

personal plans were not in an accessible format to the residents

the timelines or names of those responsible for pursuing objectives in the personal plan were not recorded

residents/relatives were not consistently involved in reviews

there was no evidence of multidisciplinary involvement in the reviews.

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:
The centre consisted of one large two story detached house set in extensive grounds in a rural location in Co Wexford. There were seven bedrooms in total five of these are for residents use and the other two are used as sleepover rooms for staff. All residents have a single bedroom. The bedrooms were seen by the inspectors to be large and were fully furnished to a good standard and provided ample storage for clothing and personal belongings.

The person in charge said residents were welcome to bring in articles of furnishings in order to personalise their rooms if they wished and most had personalised their rooms with photographs of family and friends and personal memorabilia. There were adequate shower and bathroom facilities with two bathrooms upstairs and a shower room with toilet downstairs and a second separate toilet beside the laundry room.

There was ample communal accommodation which included two sitting rooms, a kitchen and a dining room. There was a log cabin in the grounds of the centre which contained an office, exercise room, sensory room and an activity area for residents use.

The centre was seen not to be visibly clean with dust and cobwebs seen throughout the centre this will be discussed further under outcome 07. Although some parts of the centre had recently been decorated the living room and other parts of the premises were seen to be in need of redecoration due to paint off the ceilings and walls. Some of the furniture in the living rooms were also seen to be torn and in need of repair.

Laundry facilities were provided and were adequate. Staff said laundry is generally completed by staff but residents are encouraged to be involved in doing their own laundry.

As the residents tended to be mostly independently mobile, specialist equipment for use by residents or people who worked in the centre was not required.

The house was set in very large secure grounds with car parking facilities to the front and the gardens to the rear contained suitable garden seating and tables provided for residents use. There were walkways around the property and vegetable growing plots, tunnels and hen houses. As discussed in outcome 07 risk assessments are required for

these areas.

Judgment:
Non Compliant - Moderate

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:
There was a risk management policy in place and which identified the hazard identification and incident reporting process and contained the measures and actions in place to control the following specified hazards as identified in the legislation:

•unexpected absence of a resident
•accidental injury
•aggression and violence
•self-harm.
However there were a number of areas of risk in the centre particularly in relation to the outdoor areas which included farming, horticultural, care of animals and other activities that were not included in the risk register for the centre.

There was an incident reporting process and the inspectors saw that incidents were recorded in the centre, these were then faxed up for team leader and person in charge for review and comment which was then faxed back to the centre with the managers review/action to be taken on it and the part two section had the person in charges review. This process was meant that in some cases there were three copies of the one incident in the incident folder. Inspectors were not satisfied that all incidents were followed up appropriately with recommendations being put in place to prevent the accident happening again.

Accidents and incidents documented at the centre and a recent notification received by the Authority was reviewed by inspectors. Inspectors found that there were no risk assessments completed in relation to the incident notified to the Authority. Therefore inspectors concluded that the resident's safety was compromised as an area of vulnerability was identified and individual safeguards were not in place

There was an emergency plan which identified the arrangements in place to respond to emergencies like fire, management of a seizure, accidents, missing person. However the emergency plan did not include measures in place to respond to adverse weather

conditions, outbreak of an epidemic, loss of power and loss of heating, loss of cooking and laundry facilities. This was also a finding on the previous inspection.

The fire policies and procedures were centre-specific. There were notices for residents and staff on "what to do in the case of a fire displayed". The inspector examined the fire safety records with details of all checks and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment, emergency lighting and fire alarms had been tested in February 2015. In the sample healthcare files seen by the inspector each resident had a personal emergency evacuation plan which included procedures for evacuation. Records indicated that regular fire evacuation drills had taken place with for four drills taking place in February 2015, one which included training on extinguishers for staff. However the inspectors noted that the fire panel was in a locked wooden cabinet for safety reasons.

The key to this was locked into a cupboard in the kitchen so for the staff to check the panel to establish where the fire is they first have to go to the kitchen and unlock the cupboard to get the key to open the fire alarm cupboard. This process was found to be very cumbersome and would cause delays in establishing where a fire is. The policy also states in the event of fire the padlock to the bottom gate be opened by staff to allow access to the fire brigade onto the premises. The key to the padlock was also stored in the locked cupboard in the kitchen. The whole process requires review to ensure immediate action can be taken in the event of any fire. Wexford councils fire engineer's report 2014 was seen by inspectors had a number of recommendations. Inspectors asked the provider if all the recommendations had been implemented. The provider stated that she was unsure and would revert to inspectors. To date this has not occurred.

There were guidelines in relation to control and prevention of infection and there were hand hygiene posters around hand basins, liquid soap and paper towels were provided. There were cleaning schedules in place and the person in charge and staff informed the inspector that the cleaning of the centre was undertaken by all staff once their caring duties were completed. However the inspectors noted that the centre was not visibly clean with dust and cobwebs evident throughout the centre and the kitchen cooking areas was particularly noted to be in need of a deep clean. Cork notice boards which were torn were also seen on the walls of the kitchen which are an infection control hazard.

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):
This was the centre's first inspection by the Authority.

Findings:
Policies and procedures were in place for the prevention, detection and response to abuse. Staff with whom inspectors spoke knew what constituted abuse and said they had received recent training from the person in charge in adult protection. However, some of the staff who spoke with inspectors did not accurately reflect the actions they should take in the event of an allegation, process for support of and protection of residents pertinent to the nature of the allegation and the personnel who may be involved.

Inspectors were told by staff of some ongoing inappropriate behaviour of certain staff members towards residents which they said they said they had not informed the person in charge or provider about. The provider said she was unaware of these alleged allegations and assured inspectors it would be investigated immediately. Inspectors were also informed by staff of a potentially abusive situation occurring the previous weekend which had been reported to the person in charge. The person in charge confirmed when questioned by the inspectors that she had been told about an incident. However this was not recorded as an allegation of abuse and there was no documentation available in relation to the incident and as the person in charge did not think it was necessary.

Inspectors were not assured that where concerns arise for the safety of individuals that the person in charge and provider takes reasonable and proportionate measures to ensure the protection of all individuals in advance of the outcome of any assessment or investigation into the matter. Inspectors were not assured that staff understood their duty of care to report any past or current concerns for the safety of the residents in the house

Following the third day of inspection the provider contacted the Authority and informed the Authority that a staff member had been placed on administrative leave due to an alleged allegation of a abuse. However, inspectors had informed the provider and person in charge of these alleged allegations at the feedback meeting following inspection six days earlier on 11 March 2014. A notification in relation to this alleged allegation was submitted to the Authority on 20 March 2014. Inspectors were also not assured that there was robust oversight of the centre or that staff were fully supported

as the person in charge was actively managing and based in two other centres which were located approximately 214km from this centre. The provider only visited the centre very infrequently. This will be discussed further under outcome 14.

On review of the personal plans the inspectors saw that a number of residents had behaviour support plans; improvements were required. Not all behaviour support plans reviewed had proactive strategy and did not accurately detail the behaviours. These support plans had not been reviewed by a relevant professional since 2013. There were no formal medical records kept on site so inspectors could not see frequency of medical reviews. This lack of systematic management of information causes a potential risk to ensuring residents received adequate and appropriate care. It can also lead to confusion and potential for error.

Some of the residents also required additional supports in relation to behaviours that challenge. Inspectors reviewed the incident log and found that the previous weekend there had been several incidents in relation to challenging behaviour. On that particular weekend there was one staff member on duty that had not completed any training in relation to behaviours that challenge. She was one of only two staff on duty and as all of the residents have complex needs this training was paramount to ensure that staff responded appropriately to residents needs and provided positive behavioural support.

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Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
The centre had a log of incidents and accidents which the inspectors reviewed. The Authority had received notifications from the centre. However the Authority did not receive all necessary notifications including an alleged allegation of abuse within the designated timeframe as stipulated in the Regulations.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
It was unclear from reviewing resident's personal plans if their wishes and aspirations regarding training, education and employment were known or that this was assessed or explored on behalf of the residents as there was no supporting documentation available. None of the residents attended day services.

There was no evidence of any planning or discussions, with residents, to identify their preferences to access opportunities for education, training and employment.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
The level of support which individual residents required varied as observed by inspectors. There were deficiencies in the management of aspects of residents' health care.

As outlined under Outcome 5 there was very limited multidisciplinary input for residents. The PIC said that residents' had access to a general practitioner (GP) of their choice. However, there were no formal medical records kept on site so inspectors could not see frequency of medical reviews. This lack of systematic management of information causes a potential risk to ensuring residents received adequate and appropriate care. It can also lead to confusion and potential for error.

There was evidence of very limited interdisciplinary team involvement in residents' care since 2013 such as speech and language therapy, dental, neurologist, ophthalmic, occupational therapy, General Practitioner (GP) and psychiatric services. Inspectors were told by the person in charge that these services were not available from the HSE. The person in charge had not followed through on any further multi disciplinary input for residents for over two years. This approach to coordinating and directing care does not support the continuity of treatment or promote best possible health.

Inspectors were not assured that the person in charge promoted good communication between relevant health professionals to support and enhance health promotion for residents. There was no evidence that residents had access to screening, early detection or any other health and welfare services in the community.

Inspectors were not assured that each resident's assessed health needs were reviewed and met on an ongoing basis. As outlined under Outcome 8 residents that displayed self injurious behaviour were not reviewed by the appropriate allied health professionals. There was no evidence of any assessments in relation to mental capacity.

Inspectors saw that one resident had a specialised diet. There were no appropriate referrals for dietetic reviews. Inspectors were told by staff that the resident's parent managed the diet. There was no evidence that the malnutrition universal screening tool (MUST) which was an established weight monitoring/assessment tool formed part of the resident's assessment on admission to the centre.

Inspectors saw that body weight was monitored for some residents. However, inspectors could not ascertain if any actions were taken on foot of a resident being overweight or underweight. There no were menus displayed in the centre which offered choice. Some questionnaires received by the Authority indicated that it would be good for residents to have more choice.

In the house staff told the inspectors that some residents liked to help preparing the meals Inspectors observed residents making their own drinks and snacks.

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

Findings:
There were centre specific medication management policies and procedures in place which were viewed by the inspector. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed distinguished between PRN (as needed), short-term and regular medication and maximum amount for PRN medication to be administered within 24 hour period was stated on all of drug charts reviewed this was an action required on the previous inspection that had now been completed. The signature of the GP was in place for each drug prescribed in the sample of drug charts examined.

Residents all had assessments completed on their ability to self medicate which were seen in their personal plans but all residents were assessed as not being competent. In this centre medication was administered by non nursing staff. The staff demonstrated an awareness of medication management and all staff had completed safe awareness in medication management training and received regular update training which was evidenced in their training records.

The inspector saw that the medication was dispensed from the local pharmacy for each resident; in a blister pack system The inspector saw that references and resources were readily accessible for staff to confirm prescribed medication with identifiable drug information. This included a physical description of the tablets which is essential in the event of the need to withhold a medication or in the case of a medication being dropped and requiring replacement. This was also an action required on the previous inspection that had now been completed.

There was no evidence that the pharmacist provided support on medication management for staff in the centre and staff said that the pharmacist did not provide an onsite service. However, residents were not facilitated a choice of pharmacist which is a requirement of legislation.

Inspectors were told by staff that they were told by the on call cover the previous weekend to give panadol to a resident. However, inspectors saw on the medication chart that the resident had not received the medication. Inspectors could not ascertain any valid rationale as to why the resident had not received the pain relief. The protocol and current system in place was unclear, vague and insufficient to direct care staff in the absence of medical/nursing expertise .

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
The centre had a statement of purpose. However, further development was required to ensure that the statement of purpose complied with the Regulations:

Further information regarding the services which the centre provided or facilitate to meet the care and support need. The statement of purpose stated that one to one activities were available to residents however this was dependent on staffing levels and needed further clarification. The arrangements made for residents to attend religious services were unclear. The arrangements made for contact between residents and their local community was unclear. The separate facilities for day care were unclear. The statement of purpose outlined that all residents had access to a range of multidisciplinary input. This does not correlate with the findings of inspection.

The statement of purpose, in parts was also unreflective of the service provided in particular relating to resident's access to education, training and development.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
The inspectors found that there was an organisational structure in place however significant improvements regarding management systems were required to ensure compliance with the Regulations and to provide assurances to the Chief Inspector that the centre was being efficiently governed ensuring residents were being delivered a service that was safe, effective and met their needs. There was a provider nominee and a person in charge. There were 11 members on the board of management, none of these members which included the provider nominee had ever made an unannounced visit to the centre to conduct a review of the service. Inspectors were not assured that there was robust oversight of the centre or that staff were fully supported as the person in charge was actively managing and based in two other centres which were located approximately 214km from this centre. The team leader had resigned the week prior to inspection therefore there was no persons participating in the management of the centre and the person in charge only came to the centre one day per week. The provider nominee told inspectors that she visited the centre once every six months.

The time spent by the person in charge, as per the statement of purpose, in the designated centre was equated to the whole time equivalent of 0.11. She is available to staff on a daily basis by phone or email. This was found to be insufficient considering the absence of a team leader in addition to the type and number of non compliances identified throughout the inspection. Inspectors were not satisfied that she could ensure the effective governance, operational management and administration of the centre.

Appropriate supervision and guidance for qualified and unqualified staff was not found to be in place due to the lack of a robust management structure within the house. Inspectors saw that suitable and sufficient care was not provided to some residents and this indicated that there was a culture of poor care practices embedded in the service. As outlined under Outcome 11 there was no evidence of multidisciplinary team involvement for residents, there were no structured day and educational services available to residents. Inspectors observed that residents spent long periods in the house, going for spins on the bus or in the garden.

Inspectors saw there were formal support and supervision arrangements in place for staff all of which had been completed in May 2014. However inspectors could not

ascertain the value of the supervision as it did not identify goals and objectives and any issues in relation to performance and training needs that staff may require.

Information governance required improvement. The inspectors found that the person in charge had access to a computer however the staff had no access to a computer for administration purposes. The lack of information technology equipment posed a difficulty in the day to day managing and updating of personal plans. The inspectors were not assured that posting or faxing documentation to head office regarding resident's specific and personal needs was appropriate. The inspectors also found that the centres policies did not have an implementation or review date identified on each policy. It was therefore unclear to the inspectors if the polices were up-to-date.

Inspectors observed that although some audits had been conducted these were not regular or robust enough to indicate improvements required or give clear direction on evidenced based care. There was no evidence to support that a systematic, constructive and proactive culture and system was in place for reviewing the quality and safety of care and services provided to residents.

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 provider said that she would deputise for the person in charge in the event of a proposed absence of the person in charge.

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:
The provider said that the designated centre was resourced appropriately to ensure the effective delivery of care and support in accordance with the statement of purpose. However, inspectors observed that staffing levels at weekends remained at two staff. This is discussed in detail under Outcome 17. Staff informed the inspectors that their ability to go out with residents at weekends was affected due to other residents going home or being dropped back to the centre.

There were two part time maintenance people employed. However, as outlined under Outcome 12 parts of the main house required updating. Furniture and flooring needed to be replaced.

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):
No actions were required from the previous inspection.

Findings:
The inspectors found that improvements were required regarding the workforce to comply with the Health Act 2007 (care and support of residents in designated centres for persons (children and adults) with Disabilities) Regulations 2013. There was insufficient provision of suitable qualified staff to meet the needs of the residents. A staff member told inspectors that she was employed on a part time basis. However, due to staff shortages she was currently working on average 150 hours per month.

Staffing levels at weekends consisted of two staff which was inadequate to meet the needs of residents. Family members also expressed concern about the lack of staffing levels affecting the ability of residents to go out or engage in certain activities.

A staff member had been employed in the centre since September 2014 and still had not received training in behaviours that challenge. Some staff members were unclear whether or not they were key workers for residents which indicated to inspectors that staff did not have the skills required to plan and coordinate the support services provided to residents and to liase effectively with other organisations and professionals.

As the person in charge was not based in the centre inspectors found that this lack of supervision and support contributed directly towards the lack of communication between relevant health professionals involved in the support and treatment of residents as observed in residents personal plans.

The inspectors reviewed the roster, improvements were required to ensure the roster was reflective of the shifts and type of shifts worked by employees. It was unclear from the roster if the allotted times were morning, evening or night. There was no designated person in charge of coordinating any shift. Inspectors were told by staff members that "nobody was really in charge and they divided up the work the night before or when the shift commenced". Inspectors concluded that this method of work practice, lack of a management presence and the remoteness of the centre from the provider and person in charge (in excess of 214km) compromised resident's safety and well being.

The centre also had sleep over staff this was also not clearly denoted on the roster. Inspectors also observed that on occasions siblings worked together which was not in line with best practice or the centre's own policy. It was also noted on questionnaires received by the Authority that some relatives were not satisfied with certain aspects of care provided when certain staff members were on duty. This was discussed with the provider and person in charge at the feedback meeting.

Inspectors were not assured that there were systems in place to support and promote the delivery of quality care services or that there were systems in place to effectively manage risk.

There were on call arrangements for weekend cover. However, inspectors found that this system was not appropriate or robust as a team leader in another centre gave advice by phone only. These team leaders had never visited the centre and were giving advice in relation to residents and staff who they were not familiar with which creates a potential risk of error.

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 reviewed the centre's policies and procedures and found that all of the written operational policies as required by Schedule 5 of the Regulations had been developed. Initially the policies that were located on site did not have an implementation/review date and had not been signed off by the management team. The provider had rectified this by day three of inspection.

However, some policies required further development. The food and nutrition policy failed to offer guidance to staff to support residents with particular dietary requirements. The food and nutrition policy also failed to refer to the need to refer residents onto specialist such as speech and language therapy and/or dietician.

The policy regarding behaviours that challenge failed to outline the need for specialist support, external to the service, in circumstances where the behaviours were not reducing or where further specialist support such as a behaviour therapist maybe required. There were no medical records on site as outlined under Outcome 11.

A directory of residents was maintained in the centre which was in accordance with legislation. The inspectors were provided with a copy of an insurance certificate which confirmed that there was up to date insurance cover in the centre.

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:

Ide Batan
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 The Irish Society for Autism
Centre ID:	OSV-0002000
Date of Inspection:	10 March 2015
Date of response:	11 May 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found there was not a good culture of advocacy within the centre. The provider and person in charge had been informed by inspectors on day two of inspection of an alleged incident of abuse. On day 3 of inspection which took place six days later the person in charge and provider told inspectors that they had spoken to all staff. However, the resident had not been consulted or supported and facilitated to access advocacy services in relation to the alleged allegation

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

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

Please state the actions you have taken or are planning to take:
In order to ensure that each resident has access to advocacy services, the Registered Provider has made available information in relation to the National Advocacy Service for people with Disability to residents and their representatives and will ensure that staff are familiar with the service and how to access it. Pictorial and written prompts are available to residents and their representatives on the services available.

Proposed Timescale: 20/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre, such as through residents meetings or resident/relative surveys.There was no evidence of any regular house meetings between residents and staff.

2. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
The Registered Provider will cause regular house meetings to occur between residents and staff to facilitate the participation of the residents in the organisation of the centre and the outcomes will be documented.

The Registered Provider has developed a resident-accessible consultation form to ensure that each resident can participate in the organisation of the centre. For any resident for whom such a form is not sufficient, the resident's representative will work with the resident to ensure his or her wishes are known and communicated.

Proposed Timescale: 23/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests, capacities and developmental needs. In addition the inspectors also found that outings were mostly group based activities; one to one

activities and outings were infrequent. Overall, inspectors observed that activities were led by routine and resources not the resident and their support needs and wishes.

3. 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:
The Person in Charge has instructed staff to ensure that each resident is given the opportunity to provide input into the programme of activities by expressing his or her wishes about activities in accordance with their interests, capacities and developmental needs. A resident-accessible form has been developed to assist in ascertaining each resident's support needs and wishes. For any resident for whom the resident accessible form is not sufficient, that resident's representative will work with the resident to ensure his or her support needs and wishes are known and communicated. An activity meeting was held on April 24th, 2015, at which residents and their representatives communicated to staff the activities in which they wish to participate. The desired activities are documented and are being actioned. The residents' support needs and wishes are being documented in each resident's personal plan. The Person in Charge has also instructed staff to ensure that all activities undertaken by any resident are recorded in that resident's personal plan.

Proposed Timescale: 20/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaint policy was not publicly displayed.

4. Action Required:
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
The policy is now displayed publicly within the centre and is available for review by the Inspectors.

Proposed Timescale: 25/03/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints log did not record if the complainant was satisfied or not

5. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
To ensure that the complaints log is completed fully and in accordance with the Regulations, the Person in Charge, as the nominated person, has amended the format of the complaints log to include a column in which there will be recorded whether or not the complainant was satisfied. The Person in Charge will ensure that a record of all complaints is kept, including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the complainant was satisfied. Monitoring will be accomplished on an ongoing basis by the review of the complaints log for the designated centre every three months by the Deputy Executive Director of the Registered Provider, and by regular internal audits conducted by the newly appointed Senior Compliance and Quality Manager.

Proposed Timescale: 21/04/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no second nominated person to respond and maintain complaint records as required under regulation.

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

Please state the actions you have taken or are planning to take:
The Registered Provider has reviewed the complaints procedure to ensure it includes a nominated person other than the person nominated in Regulation 34(2) (a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained. The complaints policy and procedure is available for review by Inspectors.

Proposed Timescale: 25/03/2015

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

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was minimal integration with the local community.

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

Please state the actions you have taken or are planning to take:
To comply with Regulation 13 (2) (c), the Registered Provider will ensure that residents' wishes regarding integration with the wider community are heard, documented and implemented. Staff will meet with each resident and his or her representative to ascertain the resident's wishes with regard to activities within the local community and these will be documented in each resident's personal plan together with the name of person or persons responsible for ensuring the resident's wishes are achieved and a timeline for accomplishing the goal. The Registered Provider will ensure that supports are provided to facilitate the accomplishment of each resident's wishes. Participation in activities within the local community will be reviewed at activities planning meetings that will take place every six weeks going forward. These meetings will, on a continuous basis, ascertain and document the wishes of each resident. The Person in Charge will monitor this to ensure that each resident's wishes are being addressed, that the residents have access to a range of activities in line with their needs and preferences, and that the supports needed to develop and maintain personal relationships and links within the local community are available.

Proposed Timescale: 31/05/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of any multidisciplinary input for residents.

8. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
The residents attend the practice of a local General Practitioner on an as-needed basis, and each has seen the GP within the last seven months. Two of the residents have been seen by a psychiatrist, one in April and one several times in April and May, 2015. One of the residents was seen by a neurologist in March 2015. Another resident

attends regularly with an alternative health practitioner. The Person in Charge has contacted the Autism Liaison Nurse, who will visit the Designated Centre on May 13th, 2015. The Person in Charge has also contacted a dentist who works with people with disabilities. In advance of appointments being made, the Person in Charge is providing information to the dentist about the residents. In addition, the Person in Charge has contacted the Disability Services Manager at the Health Service Executive Wexford to obtain appropriate contact information for a range of Allied Health Professionals, including speech and language therapists, dieticians, behaviour support therapists, and occupational therapists. Upon receipt of the contact information, the Person in Charge will arrange appointments with the relevant disciplines so that Allied Health Professionals can provide input into the ongoing review of the residents' care plans. As part of the process of reviewing and revising each resident's personal plan, in consultation with the resident and his or her representative, all multi-disciplinary input will be documented in each resident's personal plan.

Proposed Timescale: 15/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not in an accessible format to the residents as observed by inspectors.

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

Please state the actions you have taken or are planning to take:
The Registered Provider has met with external experts in communication with people with autism to determine the most suitable and efficient way to format the residents' personal plans in a resident- accessible manner. Upon receipt of feedback the Registered Provider will implement the most appropriate method.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The timelines or names of those responsible for pursuing objectives in the personal plan were not recorded in some personal plans as observed by inspectors.

10. 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:
The revised template of personal plan contains a section entitled "Annual Person Centred Plan." The Person in Charge has included the timelines and names of people responsible for pursuing objectives in this section. This will be reviewed by the Person in Charge not less than every six months, or more frequently if there is a change in needs or circumstances, and will be part of the regular internal audits to be conducted by the Senior Compliance and Quality Manager.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate evidence of consultation with residents and their relatives in relation to the development of plans and there was inadequate evidence that plans were based on the aspirations and choices of residents.

11. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
The Person in Charge will review and revise as needed each resident's personal plan, in consultation with the resident and his or her representative. All such consultations will be documented to demonstrate the involvement of the residents and their representatives. The Person in Charge will ensure that the contents of the residents' personal plans will be developed with the maximum participation and input of the residents, and will document consultations to show that plans are so based.

Proposed Timescale: 30/06/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the furniture in the living rooms were also seen to be torn and in need of repair.

12. 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:
The Registered Provider has replaced worn furniture in the living rooms of the designated centre, including couches. To ensure that equipment and facilities for use by residents and staff are maintained in good working order, an audit of the premises of the Designated Centre will be undertaken on a six -monthly basis beginning in July 2015, or more frequently if needed, and equipment and furniture will be replaced if the outcome of the audit indicates it is needed.

Proposed Timescale: 20/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was seen not to be visibly clean with dust and cobwebs seen throughout the centre and parts of the premises were seen to be in need of redecoration due to paint off the ceilings and walls.

13. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
The Registered Provider arranged that all deficits identified under the outcome Safe and Suitable Premises were rectified appropriately. The designated centre was deep cleaned on April 15th & 16th, 2015 and some walls and ceilings, among other areas, were painted on April 15th & 16th, 2015. The cleaning rota will be reinforced and the Person in Charge will conduct an internal hygiene audit fortnightly. A regular inspection, commencing July 2015, will be undertaken by the Person in Charge and during internal audits conducted by the Senior Compliance and Quality Manager.

Proposed Timescale: 20/04/2015

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:
There were a number of areas of risk in the centre particularly in relation to the outdoor areas which included farming, horticultural, care of animals and other activities that were not included in the risk register for the centre.

14. 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:
The Registered Provider will review the risk management register and will implement the changes identified. The Registered Provider will ensure the risk register is centre-specific and includes hazards and risks relating to the walkways around the property, vegetable growing plots, tunnels and hen house. The risk register will also include hazards and risks relating to the outdoor areas where farming, horticulture and care of animals take place. Hazard and risk inspections will be carried out regularly and any hazards or risks will be identified. Risk assessments may then be amended in accordance with the findings of the inspections. Risk assessments will be discussed at staff meetings, and the Person in Charge will communicate any updates to staff.

Proposed Timescale: 24/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that all incidents were followed up appropriately with recommendations being put in place to prevent the accident happening again.

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

Please state the actions you have taken or are planning to take:
The Registered Provider has reviewed the risk management and assessment policy to ensure that it complies with Regulation 26(1)(d). April 20, 2015.
The Registered Provider will reinforce the obligations of staff under the policy by providing a copy of the risk management and assessment policy to staff and ensuring that staff acknowledge that they have read and understand the policy and their obligations thereunder.

Proposed Timescale: 22/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The emergency plan did not include measures in place to respond to adverse weather conditions, outbreak of an epidemic, loss of power and loss of heating, loss of cooking and laundry facilities.

16. 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 Registered Provider will revise the emergency plan. It will be detailed and centre-specific and will include measures to respond to adverse weather conditions; outbreak of an epidemic; loss of power; loss of heating; loss of cooking; and loss of laundry facilities. The Person in Charge will inform staff of the updates, and will provide copies of the revised plan to staff. The revised plan will be available for review by the Inspectors

Proposed Timescale: 24/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors noted that the centre was not visibly clean with dust and cobwebs evident throughout the centre and the kitchen cooking areas was particularly noted to be in need of a deep clean. Cork notice boards which were torn were also seen on the walls of the kitchen which are an infection control hazard

17. 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:
The Registered Provider arranged for the deep cleaning of the Designated Centre on April 15th & 16th, 2015. The cork notice boards in the kitchen were replaced. April 16, 2015
To ensure the residents are protected against healthcare associated infections, the cleaning rota will be reinforced and the Person in Charge will conduct an internal hygiene audit fortnightly.
The Senior Compliance and Quality Manager will also undertake a hygiene inspection as part of the regular internal audits she will be conducting and any noted deficits will be rectified promptly and appropriately.

Proposed Timescale: 16/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The process to respond to fires immediately was impeded by a non visible fire alarm

panel and access to the property by the fire brigade was impeded by a padlocked gate which staff did not have immediate access to open.

18. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
The fire alarm panel was adapted by the inclusion of a Perspex screen to make the panel visible. The lock was removed from the gate.

Proposed Timescale: 20/04/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One staff member had not completed any training in relation to behaviors that challenge.

19. 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 Person in Charge has reviewed the mandatory training requirements for staff, and, where necessary, has arranged for updates and/or refresher training. A copy of the training records for staff is held in the Designated Centre. Training in working with behaviours that challenge was delivered by an external provider on March 26, 2015. Staff members who were unable to attend those training sessions will attend one of the next sessions, which are scheduled to occur in June 2015. The Person in Charge will review the individual training requirements for each staff member twice a year and will coordinate with the Registered Provider to arrange training as needed.

Proposed Timescale: 30/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all behaviour support plans reviewed had proactive strategy and did not accurately detail the behaviours. These support plans had not been reviewed by a relevant professional since 2013.

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

Please state the actions you have taken or are planning to take:
Six staff received training in Behaviours that Challenge in the last 4 months. These staff are trained to complete behaviour support plans. Behaviour Support Plans are being reviewed by the Person in Charge. The Person in Charge will, in consultation with the resident and their representatives, ensure that the Behaviour Support Plans have proactive strategies and accurately detail resident's behaviours.

Proposed Timescale: 31/05/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that staff understood their duty of care to report any past or current concerns for the safety of the residents in the house

21. 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:
In order to ensure that staff understand their duty of care to protect residents from all forms of abuse, which includes the obligation to report any past or current concerns about the safety of the residents, the Person in Charge has, where necessary, arranged for updates and/or refresher training in working with vulnerable adults. This was provided on March 23, 2015 by an external consultancy group. Staff members who were unable to attend the March 23rd training will attend another session, which is to be scheduled. (To be scheduled)
In addition, the Person in Charge is ensuring that staff are aware of their duty of care to protect residents from all forms of abuse by ensuring that staff acknowledge they have read and understand the Policy and Procedures for the Protection of Vulnerable Adults. (24/04/2015)
The Registered Provider training in protection of vulnerable adults will be reinforced with staff on an annual basis. (Ongoing)

Proposed Timescale: 24/04/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that where concerns arise for the safety of individuals that the person in charge and provider takes reasonable and proportionate measures to

ensure the protection of all individuals in advance of the outcome of any assessment or investigation into the matter. Inspectors were not assured that staff understood their duty of care to report any past or current concerns for the safety of the residents in the house

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

Please state the actions you have taken or are planning to take:
The Person in Charge is ensuring that staff are aware of their duty of care to protection residents from all forms of abuse by ensuring that staff acknowledge they have read and understand the Policy and Procedures for the Protection of Vulnerable Adults.

Proposed Timescale: 24/04/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff who spoke with inspectors did not accurately reflect the actions they should take in the event of an allegation, process for support of and protection of residents pertinent to the nature of the allegation and the personnel who may be involved

23. 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:
In order to ensure that staff understand their duty of care to protect residents from all forms of abuse, which includes the obligation to report any past or current concerns about the safety of the residents, the Person in Charge has, where necessary, arranged for updates and/or refresher training in working with vulnerable adults. This was provided on March 23, 2015 by an external consultancy group. Staff members who were unable to attend the March 23rd training will attend another session, which is to be scheduled. (To be scheduled)
In addition, the Person in Charge is ensuring that staff are aware of their duty of care to protect residents from all forms of abuse by ensuring that staff acknowledge they have read and understand the Policy and Procedures for the Protection of Vulnerable Adults. (24/04/2015)
The Registered Provider training in protection of vulnerable adults will be reinforced with staff on an annual basis. (Ongoing)

Proposed Timescale: 24/03/2015

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:
The Authority was not notified within the designated timeframe of an alleged allegation of abuse.

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

Please state the actions you have taken or are planning to take:
The relevant notification of an allegation of abuse was submitted to the Authority on March 20, 2015. Any allegation of abuse that occurs in the future will be notified to the Authority within the required time frame.

Proposed Timescale: 11/05/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no assessments or plans in place to support education, training and or employment.

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

Please state the actions you have taken or are planning to take:
The Person in Charge has contacted the Disability Services Manager with the Health Service Executive Wexford requesting information about day services for the residents. The Person in Charge will also discuss this issue with the Autism Liaison Nurse on May 13th, 2015. In the interim, the Person in Charge will begin consulting with each resident and his representative to ascertain and document his preferences with regard to accessing opportunities for education, training and employment.

Proposed Timescale: 15/05/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence of very limited interdisciplinary team involvement in residents' care since 2013 such as speech and language therapy, dental, neurologist, ophthalmic, occupational therapy, General Practitioner (GP) and psychiatric services. Inspectors were told by the person in charge that these services were not available from the HSE.

26. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
The Person in Charge will assess the needs of each resident, which will be documented in the residents' personal plans. Based on the assessment of needs, Allied Health Professionals will be accessed as appropriate. In anticipation of needing Allied Health Professionals, the Person in Charge has contacted the Disability Services Manager with the Health Service Executive Wexford to obtain contact information for a variety of Allied Health Professionals, including speech and language therapists, occupational therapists, psychiatrists, and dieticians. The Person in Charge has also contacted a dentist who provides services to people with disabilities, and is in the process of providing the required information to the dentist in order to arrange appointments. The Person in Charge has also contacted the Autism Liaison Nurse, who will visit the Designated Centre on May 13th, 2015. Going forward, the Person in Charge will review the needs of each resident not less than annually and as may be required if circumstances or needs change in the interim. Senior management of the Registered Provider will review each resident's personal plan not less than annually to ensure that a resident's needs are accurate and current, and the Senior Compliance and Quality Manager will include a review of the residents' needs and consequent involvement of Allied Health Professionals in her regular internal audits.

Proposed Timescale: 15/05/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that residents had access to screening, early detection or any other health and welfare services in the community.

27. Action Required:
Under Regulation 06 (2) (e) you are required to: Support residents to access appropriate health information both within the residential service and as available within the wider community.

Please state the actions you have taken or are planning to take:
The residents attend the practice of a local General Practitioner on an as-needed basis, and each has seen the GP within the last seven months. One of the residents was seen by a psychiatrist in April, 2015, and another resident has been seen several times in April and May, 2015. One of the residents was seen by a neurologist in March 2015. Another resident regularly attends an alternative health practitioner. The Autism Liaison Nurse will visit the Designated Centre on May 13th, 2015. In addition, the Person in Charge has contacted a local General Practitioner to arrange an annual health check for the residents, which will include blood tests, diabetes testing, prostate cancer testing, and general wellbeing. The Person in Charge will ensure that supports are available to the residents so that they are facilitated to access the appointments

Proposed Timescale: 06/05/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There no were menus displayed in the centre which offered choice.

28. Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
The Person in Charge will consult with each resident to assess his or her dietary needs and preferences, and will document this in each resident's personal plan. In the interim, staff meet with residents every week to discuss the menu. Menus have been developed to reflect the residents' dietary preferences and are displayed in the Designated Centre in standard format. The Person in Charge will develop a resident-accessible format, and representatives of the residents will ensure that the menus are accessible for residents.

Proposed Timescale: 30/04/2015

Outcome 12. Medication Management

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not facilitated a choice of pharmacist which is a requirement of legislation.

29. Action Required:
Under Regulation 29 (1) you are required to: Ensure that a pharmacist of the resident's

choice or a pharmacist acceptable to the resident, is as far as is practicable, made available to each resident.

Please state the actions you have taken or are planning to take:
The Person in Charge will arrange that staff meet with each resident and ensure that a pharmacist of the resident's choice is available, or that the pharmacist the resident is using, is acceptable. This will be documented in each resident's personal plan and will be revisited annually or sooner if the need arises. The pharmacist currently supporting the Designated Centre attended on-site on April 14, 2015.

Proposed Timescale: 30/06/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors could not ascertain any valid rationale as to why a resident had not received the pain relief that he had been prescribed for. The protocol and current system in place was unclear, vague and insufficient to direct care staff in the absence of medical/nursing expertise .

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

Please state the actions you have taken or are planning to take:
The Registered Provider previously developed a Medication Management Policy and Procedures, which is in accordance with the requirements of Schedule 5 of the Regulations. This Policy supports the appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines. The Person in Charge will ensure that SAM-trained staff acknowledge that they have read, understand and are familiar with the procedures contained within the Medication Management Policy and Procedures.

Proposed Timescale: 23/04/2015

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:
Further development of the statement of purpose was required to ensure that it complied with the Regulations.

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

Please state the actions you have taken or are planning to take:
The Registered Provider will review the Statement of Purpose to ensure that it includes all elements required by Schedule 1 of the Regulations (2013) of the Health Act 2007. Copies of the Statement of Purpose will be available for all residents and their representatives and for review by the Inspectors.

Proposed Timescale: 12/05/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that the person in charge could ensure the effective governance, operational management and administration of the centre as she was not based in the centre on a fulltime and consistent basis

32. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
In order to ensure the effective governance, operational management and administration of the designated centre, a new Person in Charge has been appointed, starting May 5, 2015, who will be responsible only for this designated centre. In the interim, the Deputy Executive Director is in contact with the current Person in Charge daily to ensure that the centre is being governed, managed and administered thoroughly. Subsequent to May 5, 2015, the Deputy Executive Director will continue to monitor the Designated Centre to be assured that governance, operational management and administration of the Designated Centre is sufficient and effective.

Proposed Timescale: 05/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no clearly defined management structure in the centre that identified the

lines of authority, accountability, specific roles and detais responsibilities for all areas of service provision.

33. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The Registered Provider has developed a new management structure, and a copy of that revised management structure is attached. A new organogram of staff within the Designated Centre with lines of authority, accountability and details of responsibilities is being developed.

Proposed Timescale: 31/05/2015

Theme: Leadership, Governance and Management

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

34. 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 Registered Provider has developed a new management structure, and a copy of that revised management structure is attached. An organogram of staff within the Designated Centre has been updated and now shows lines of authority, accountability and details of responsibilities. In conjunction with the foregoing, the Registered Provider has consolidated disparate processes into a structured management system, which will be embedded in the Designated Centre.

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors saw there were formal support and supervision arrangements in place for staff all of which had been completed in May 2014. However inspectors could not ascertain the value of the supervision as it did not identify goals and objectives and any issues in relation to performance and training needs that staff may require.

35. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
The Registered Provider has hired a new Person in Charge, who will begin working at the Designated Centre on May 5, 2015. The Registered Provider has developed a staff supervision and performance management form. The new Person in Charge will ensure that formal documented one-to-one consultations with staff happen at least every six months, and informal meetings will continue to happen more regularly and as appropriate or required. The first formal one-to-one consultations will be concluded by June 30, 2015.

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that although some audits had been conducted these were not regular or robust enough to indicate improvements required or give clear direction on evidenced based care. There was no evidence to support that a systematic, constructive and proactive culture and system was in place for reviewing the quality and safety of care and services provided to residents.

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

Please state the actions you have taken or are planning to take:
The Registered Provider has hired a new Senior Compliance and Quality Manager, who commenced employment on April 8, 2015. This employee will be conducting announced and unannounced internal audits of all the Designated Centres run by the Registered Provider on a regular basis, and at least once every six months, and ensuring that all Designated Centres are compliant with both the Regulations and best practices. The results of the Senior Compliance and Quality Manager's audits will be documented and action plans will be put in place to rectify any deficits observed.

Proposed Timescale: 15/05/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that staffing levels at weekends remained at two staff. Staff informed the inspectors that their ability to go out with residents at weekends was affected due to other residents going home or being dropped back to the centre.

37. 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 Registered Provider commissioned an external review of staffing levels and skill mix. If and when the level of activities requires it, then the Registered Provider will increase staffing levels appropriately. The new Person in Charge will oversee the staffing levels and requirements for extra staff on an ongoing basis after May 5, 2015.

Proposed Timescale: 05/05/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient provision of suitable qualified staff to meet the needs of the residents.

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

Please state the actions you have taken or are planning to take:
The Registered Provider commissioned an external review of the number, qualifications and skill-mix of staff throughout the Designated Centre. A new Person in Charge will begin working at the Designated Centre on May 5, 2015. The new Person in Charge will be responsible for, and will coordinate with the Registered Provider to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the specific requirements of the Designated Centre. In the interim, the Person in Charge is monitoring the staffing needs of the Designated Centre and is working with the Registered Provider to ensure sufficient suitably qualified staff are provided to meet the needs of the residents.

Proposed Timescale: 11/05/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors reviewed the roster, improvements were required to ensure the roster was reflective of the shifts and type of shifts worked by employees. It was unclear from the roster if the allotted times were morning, evening or night. There was no designated person in charge of coordinating any shift.

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

Please state the actions you have taken or are planning to take:
The Person in Charge has revised the roster, which now reflects the actual shifts and types of shifts that staff work in the Designated Centre. The Person in Charge is responsible for coordinating any shift. The rosters are informed by and reflective of the organogram of staff within the Designated Centre that incorporates lines of authority, accountability and details of responsibilities.

Proposed Timescale: 20/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As the person in charge was not based in the centre inspectors found that this lack of supervision and support contributed directly towards the lack of communication between relevant health professionals involved in the support and treatment of residents as observed in residents personal plans.

40. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
A new Person in Charge has been appointed, starting May 5, 2015, who has responsibility only for this designated centre. In the interim, the Deputy Executive Director is in contact with the current Person in Charge daily to ensure that the centre is being governed, managed and administered thoroughly.

Proposed Timescale: 11/05/2015

Theme: Responsive Workforce

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

A staff member had been employed in the centre since September 2014 and still had not received training in behaviours that challenge.

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

Please state the actions you have taken or are planning to take:
The Person in Charge has reviewed the mandatory training requirements for staff, and, where necessary, has arranged for updates and/or refresher training. A copy of the training records for staff is held in the Designated Centre. Training in working with behaviours that challenge was delivered by an external provider on March 26, 2015. Staff members who were unable to attend those training sessions will attend the next scheduled session. The Person in Charge will review the individual training requirements for each staff member twice a year and will coordinate with the Registered Provider to arrange training as needed.

Proposed Timescale: 30/06/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies as outlined in Outcome 18 required a review to ensure that the guidance and procedure sufficiently guided staff but also reflected the service provided.

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

Please state the actions you have taken or are planning to take:
The Registered Provider has instituted an organisation-wide plan to review the policies and amend as required. The Registered Provider intends that all policies will be in full compliance with the requirements of the Regulations and will sufficiently guide staff and reflect the service provided.

Proposed Timescale: 31/05/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no medical records on site.

43. 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:
The residents' healthcare information, as required by Schedule 3 of the Regulation, is held within the designated centre. These records are available for review by the Inspectors.

Proposed Timescale: 20/04/2015