<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
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</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0003444</td>
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<td><strong>Centre county:</strong></td>
<td>Co. Dublin</td>
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<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 39 Assistance</td>
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<td><strong>Registered provider:</strong></td>
<td>The Cheshire Foundation in Ireland</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Mark Blake-Knox</td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Deirdre Byrne</td>
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<td><strong>Support inspector(s):</strong></td>
<td>Linda Moore</td>
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<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>15</td>
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<td><strong>Number of vacancies on the date of inspection:</strong></td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times
From: 16 June 2015 09:30  
To: 16 June 2015 18:00
From: 17 June 2015 08:00  
To: 17 June 2015 15:30

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
This registration monitoring inspection of Richmond House was announced and took place over two days. As part of the inspection, inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Inspectors also received questionnaires from residents which were complimentary of the service being provided at the centre.

On the first day of inspection, inspectors found that there were a significant number of areas of non-compliance with the Health Act 2007 (Care and Support of Residents
in Designated Centres for Persons (children and adults) with disabilities) Regulations 2013. In particular, inspectors found there were inadequate staff nurse levels to meet the assessed health care needs of the residents. These issues were discussed with the person in charge at the end of the first day of inspection, and an interim plan was shown to inspectors which showed nursing care and supervision would be provided up to three and half days per week in the centre, until a nurse was recruited.

In addition, there were further areas of non-compliance with the Regulations in particular:
- the health care needs of residents, such as falls prevention and management, nutrition and dysphagia were not being adequately managed to ensure the safety of residents,
- the completion of personal plans for all residents assessed interests, likes and aspirations
- the identification and assessment of risks,
- the management of adverse events,
- infection control procedures,
- risk issues associated with medication management,
- provision of up-to-date mandatory training to staff
- provision of evidence based training for staff to meet the health care needs of residents
- the ongoing review of the safety and quality of care provided to residents and an annual review of the safety and quality of care provided to residents.

These concerns were outlined to the provider, who was requested to attend a meeting in the Authority offices on the 6 July 2015 to discuss and provide assurances that the health care needs and staff skill mix in the centre was satisfactory.

There is a de-congregation plan for the centre, and it is expected that the centre will be de-commissioned by December 2016. The residents were consulted with in the planned transition from the centre into the community and additional staff resources were in place to assist and support residents.

Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

The person in charge and staff responded very effectively to the communication support needs of residents. Residents were consulted with about the running of the service. Residents were supported by staff to pursue a variety of interests. The staff were observed to be caring and supportive to the residents and the care they provided.

Inspectors found that the provider and the person in charge had only addressed three of the seventeen actions from the previous inspection. There were eight in progress and six were incomplete.

These items are discussed in the body of the report and are included in the Action
Plan at the end of this report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents’ rights, dignity and consultation were generally supported by the provider, person in charge and staff however, improvements were required in some aspects of dignity and privacy, and the management of complaints.

The provider, person in charge and staff were committed to promoting the rights of residents. Residents told inspectors about their rights in the centre. They explained to inspectors that the staff understood their needs, supported them to make choices about their lives and treated them with respect. Residents gave many examples of how they were involved in the running of the centre for example, the trips they went on and the types of activities taking place. There were regular residents’ committee meetings where residents made decisions and asked staff for support.

Inspectors spoke to residents who told of their involvement in the development of their support plans. The residents spoke about their planned move from the centre, which will entail moving to their own home. This included the development of plans to transition into the community. However, a number of residents also reported their apprehension in the planned de-congregation to inspectors. There was a lack of information on what management were doing to support residents around these decisions.

Residents could make choices about their daily lives such as when to go to bed, what food to eat and how to spend their free time. However, inspectors were informed by residents that mealtimes were concentrated around set times as opposed to residents choice of what time they wished to eat a meal. Staff were observed interacting with
residents in a respectful manner, consulting with them and seeking their views. Although, during the lunchtime meal on the first day of inspection, one resident was supported to have their meal by staff who stood over them. These practices may compromise the resident's dignity. This was discussed with the person in charge who assured inspectors he would address the matter with staff.

There was a CCTV system in use and a policy was in place to guide practice. While cameras were limited to communal areas only, there were no notice displayed at the location of each camera confirming they were in place. This was discussed at feedback with the provider who said it would be addressed.

Residents told inspectors about their involvement with their local community including trips to the post office, supermarket, going out on day trips or home to visit family which they said they enjoyed. One resident felt they had integrated into the community over time, and met the locals and invited them into the centre which was reciprocated.

There was a policy on the care of residents’ property and finances, as required by the Regulations. The provider and person in charge had put satisfactory arrangements in place to protect the property and the finances of residents. Records read confirmed there were two signatures maintained for each transaction.

Residents were supported and encouraged to take responsibility for personalising their own bedrooms. Inspectors saw lists of residents’ possessions which were kept in the residents’ files, and these were updated regularly to ensure that residents’ property was accounted for and to prevent items going missing.

Inspectors found there were systems in place for the management of complaints. However, the complaints procedures in place were not centre specific and did not fully meet the requirement of the Regulations. For example the procedure and a policy contained different complaints officer in both. In addition, there was no person nominated to oversee the response and documentation of complaints. This was an action at the previous inspection and not fully addressed.

There was a complaints procedure displayed in the centre, and a complaints leaflet was provided. The residents spoken with told inspectors they could make a complaint to staff at any time and they were responded to. A sample of complaints were read. There was evidence each complaint was investigated however, the complainants satisfaction was not documented. The assistant manager explained this is usually recorded on electronic format and will be reflected on individuals complaint records in the future.

There was an independent advocacy service available and the staff explained to inspectors examples of input from the independent advocate. A meeting with the external advocate had been arranged for the 18 June 2015 to discuss the proposed transition to the community. However, not all residents spoken to were aware that this meeting was taking place.

**Judgment:**
Non Compliant - Moderate
### Outcome 02: Communication

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
Inspectors found that many of the staff responded very effectively to the communication support needs of residents. However, there were improvements required, and the actions are highlighted in outcomes 5 and 18.

The majority of the residents could communicate verbally and some residents described the assistive technology in place to assist them to read and write. Staff were knowledgeable of residents identified communication requirements and records read confirmed some residents had detailed information on their communication needs documented in a plan. However, some plans read were not comprehensive and would not fully guide staff practice. For example, one residents plan stated "care staff to be aware of non verbal signs". The non verbal signs that staff should look out for and how they were to communicate with the resident were not highlighted in their care plan. The action plan relating to this is included in outcome 5.

Inspectors found the centre was not provided with accessible signs and information for the residents throughout the centre. For example, menu choices, fire procedures, information, way finding notices (see outcome 18).

The residents had access to magazines, radio, TV, a telephone and the internet. There was a computer room available. Many of the the residents had their own mobile phones and some has personal computers, tablets or laptops.

**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:
Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

Residents told inspectors that family members and friends could visit at any time and some residents said that they visited their family home regularly. Inspectors did not speak with relatives at this inspection, but family members were observed to visit the centre.

Both residents and staff confirmed that if they wished to meet a visitor in private, they could one of the two sitting rooms, seating areas through the centre or their bedrooms.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
There were policies and procedures on the transition and discharge from the service of residents to the centre. However, a review of planned admissions to the centre by the provider was required.

Inspectors reviewed the transitions and discharge policy. Inspectors were informed prior to the inspection that the centre was to be de-congregated by December 2016. A transition plan was being developed for each resident. Currently there were 15 residents living in the centre. However, the provider had applied to register the centre for its maximum capacity - 20 residents. This would not be in line with the Statement of Purpose, which stated there would be no new admissions.

There was a contract of care in place that detailed the supports, care and welfare of the residents in the designated centre. It outlined the fees to be charged and was signed by the residents. However, the contracts of care reviewed did not outline the services provided for the fees charged.
Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Inspectors found each resident's wellbeing was maintained by a good standard of care and support. However, improvements were required to ensure that all residents personal plans were based on their assessed needs; that each resident had a personal plans that outlined the supports required to maximise their personal development in accordance with their wishes. The documentation in this regard was completed recently and was not comprehensive.

A number of the residents had a personal plan that outlined their hopes and goals for the future, however, not all residents had a plan developed. This had been an action from the last inspection and was a work in progress. Inspectors reviewed a sample of the residents' plans. The plans contained insufficient detail of the residents' likes and dislikes and information regarding residents’ interests. There was no information on residents’ specific social and preferred routines. Furthermore, there was no comprehensive assessment of residents emotional, participation needs and preferences. There were individualised risk assessments in place but these were not detailed and would not ensure residents continued safety. See outcome seven (risk management) and 11 (health care needs) for more detail.

Where personal plans had been developed they were based on the individual support needs of the resident, however, there was no documentary evidence of regular reviews. The personal plans were not multidisciplinary and there was no system to assess the effectiveness of the plans. There was inconsistent evidence of residents involvement in the development of the plans, and there was no accessible version provided to residents.
The staff were seen to interact closely with the residents, and facilitated activities during the inspection. Residents led very independent lives, with many going out to work, attending day services and outings on their own during the day. Some residents had the support of volunteers to accompany them out in the community and provide support in carrying out daily tasks. There were planned activities that took place in the centre. Inspectors found an action from the last inspection was in the process of being addressed and additional activities had been planned. These were facilitated by an activities coordinator and the staff. Activities included trips to the library, baking classes, board games, reading. In addition, outings took place from the centre for example, trips to see the tall ships, coffee shops, restaurants, and the local shopping centres. Inspectors noted in questionnaires from residents that there could be more outings. Some residents were facilitated and supported to go on holidays.

As reported earlier in outcome 4, there was a transition plan for each resident in the centre. It was planned to de-congregate the centre and the residents would eventually move into a community setting and their own home by December 2016. This was a carefully coordinated, organised and staged process. Three community transition coordinators were employed to work closely with the residents during this transition period. Information on the process was provided that outlined the consultation the residents, and the assessments of their needs when they had moved into the community. However, this information was not easily accessible to the residents and copies had not been provided in a format for them to understand. The residents themselves told the inspector about the move. Two resident expressed much how they looked forward to it and told inspectors about their proposed new home and the process of moving into the community. Residents had a choice in where and what type of house they would like to live in. However, as discussed under outcome 1, a number of residents also expressed apprehension and worry about the move and a desire to remain in the centre. There was a lack of information on what management were doing to allay these residents fear and worries.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective Services

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

**Findings:**
Inspectors found the premises would not fully meet the requirements of the Regulations.

The premises is located on its own extensive grounds, in an urban setting and in close proximity to the local community and the city centre. In the past it accommodated up to 20 residents. Currently, 15 residents reside in the designated centre. However, inspectors found aspects of the building did not fully meet the requirements of the Regulations. The issues were discussed with the provider. Inspectors were informed there were plans to de-commission and vacate the premises by December 2016. The deficits with the building are as follows:

- aspects of the building were not in good repair: a hole in the laundry room ceiling, torn flooring in some bathrooms,
- aspects of the centre were not in a clean condition: carpet in two resident bedrooms,
- common areas -bathrooms and the hallways- were clinical and sparsely decorated,
- offices were located in former bedrooms alongside the bedrooms where residents also lived, with noise levels from staff working in these rooms reducing the areas to workspaces as opposed to a home,
- lack of suitable storage- equipment was stored in communal bathrooms,
- some equipment not maintained in good working order.

The bedrooms were all single occupancy. A number of residents rooms were observed and found to be very pleasantly decorated to their own taste with their personal belongings and possessions. However, they were not maintained to a good standard of decoration throughout. Five bedrooms in an extension to the back of the centre were provided with en-suite facilities. Each bedroom was provided with suitable storage. There was an adequate number of toilets, showers and assisted baths provided. In addition, there were staff offices, a large catering kitchen, dining room, sitting rooms, meeting rooms, laundry, cleaning store room, sluice room.

A garden area skirts the perimeter of the building, and residents can access this area directly from the building. It was pleasantly landscaped with shrubbery and flowers. There was a tiled pavement for residents to access if they wish. However, some parts of the ground were not smooth and may pose a risk to residents who required assistance mobilizing or using a wheelchair. This is discussed in outcome 7 (risk management).

There was specialised equipment provided. However, equipment was not consistently maintained in good working order, and there was no system for checking this. For example, a hoist, weighting scales hoist was out of order for a number of weeks and had not been replaced or repaired, pressure relieving mattresses were not set correctly throughout the centre.

The infection control procedures in place required improvement. The policies in did not guide staff and cleaning procedures carried out by staff required review. For example, staff used wipes to clean specialist equipment for residents and there was no evidence based cleaning programme in place. The cleaning staff were observed to carry out cleaning and laundry duties, however, the same staff were later seen support catering staff in the dining room at meal times. This may pose an infection control risk. Furthermore, infection control training had not been provided to the cleaning staff.
**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:**
The actions from the previous inspection had not been addressed. Inspectors found that appropriate action had not been taken to respond to accidents and incidents involving residents. There were improvements required to ensure the the health and safety of residents, staff and visitors to the designated centre was promoted and protected. The assessment of risk and the management of adverse events required improvement.

Inspectors found the assessment of risk required improvement. While there was a risk management policy that met the requirements of the Regulations, it was not implemented in practice. For example, risk assessments had not been carried out apart from the use of lap-belts and bedrails. Where risk assessment were carried out, these were not comprehensive to ensure a robust risk review had been undertaken. In addition, a number of areas of potential risk identified by inspectors at the previous inspection had not been fully assessed and addressed. For example, the open entrance and electrical equipment in residents’ bedrooms. An audit from a health and safety officer was read. However, it was not robust, and did not identify these risk identified by inspectors during the inspection.

The systems in place to manage adverse events required improvement. While an accident record book was read by inspectors, in which a range of incidents were recorded, there was no evidence of the investigation carried out for incidents. For example, there were a high number of medications errors and and un witnessed falls resulting in head injuries. In addition, there was no evidence of the action taken to prevent a similar incident re-occurring. This had been an issue at the previous inspection and was not fully addressed.

An up-to-date health and safety statement was seen by inspectors.

There was an emergency evacuation plan, which included the alternative accommodation options. Personal emergency evacuation plans were in place for each resident and reviewed monthly. However, they were not correctly dated on the day of the review. This is discussed under outcome 18.
A policy on the prevention and control of infection was read by inspectors however, as described in outcome 6, the policy did not guide staff and practices observed required improvement.

There was evidence that not all staff had completed training in the movement and handling of residents. Up to eleven staff had been identified by the service as not having completed training, and two staff had not completed training since 2011. This was discussed with the provider who assured inspectors that training would be put in place.

The systems in place to manage and prevent and management of fire safety required improvement. While fire fighting equipment was provided there was lack of documentation to ascertain if the emergency lighting and the alarm system had been serviced on quarterly basis. This was discussed with the provider and person in charge who advised inspectors that this information would be provided to the Authority. This information had not been submitted to date. There were fire exits provided that were unobstructed with daily checks completed by staff. An action from the previous inspection was completed and these were up-to-date. There were staff fire drills carried out and records of a sample were read by inspectors. However, in one report the drill was stated to take 25 minutes to completed. The length of time and action was discussed with the provider and person in charge, who informed inspectors they would review the process and what times are recorded going forward. This is discussed under Outcome 18.

Although staff were able to tell inspectors what they would do if the fire alarm went off, inspectors found from records read that staff did not appropriately respond when a fire alarm went off unexpectedly. The report stated staff did not call the fire authorities due to costs of doing same. There was no evidence of what follow up action was taken to ensure a similar did not happen again.

Fire orders were displayed throughout the centre. Records reviewed by inspectors indicated that most staff had participated in fire training within the past three years. However, records read confirmed three staff have not completed this training. This was an issue at the previous inspection also, and is discussed in more detail under Outcome 17.

Inspectors were not satisfied that adequate systems were in place to prevent the spread of fire. While fire doors were provided in the bedroom area it was not clear if there were fire doors were located at the kitchen/dining room. The person in charge informed inspectors that they would update inspectors following the inspection on this matter. No update has been provided.

**Judgment:**
Non Compliant - Major

**Outcome 08: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and*
appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe Services

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

**Findings:**
Inspectors found there were measures in place to safeguard of residents and protect them from the risk of abuse. However, improvements were identified in the procedures followed to investigate allegations of abuse and the provision of up-to-date training. The implementation of the policy on the management of restrictive practices required review.

All staff spoken to were knowledgeable in the area of protection from abuse. While there was a training programme in place for staff, some staff had not completed up-to-date training as required by Regulations. For example, six staff had yet to complete refresher training, and one staff member had not completed training since 2010. This had been an action at the previous inspection which had not fully addressed. See outcome 17 (workforce).

The implementation of policies and procedures on the prevention of abuse required improvement. Prior to the inspection an allegation of abuse had been notified to the Authority. The inspectors read the report of the investigation and found the procedures for the investigation of abuse did not guide practice. For example, statements were not gathered from residents, staff or witnesses and the learning from the investigation was not robust to bring about change in practice. This was discussed with the person in charge, who had an satisfactory understanding of the procedures to follow to carry out an investigation. Inspectors found that a complaints and feedback form was used to report allegations or suspicions of abuse. This could present a risk if allegations of abuse were to be investigated as though they were a complaint, both of which are investigated under different policies. This was also an issue at the previous inspection and is discussed under Outcome 18.

The systems in place for the management of restrictive practices required improvements. There was a policy that reflected the National Policy "Towards a Restraint Free Environment". However, it was not fully implemented in practice and staff had not received training in its use. One bed-rail seen by inspectors was very loose and this could pose a risk to the resident. However, the assessment tool for the bed-rails did not include the risks associated such as entrapment due to issues such as loose or badly fitted rails. Inspectors read that the alternatives considered were "not to use bed-rails", which is not satisfactory evidence based practice. Furthermore, there were no regular
checks when bed-rails were in place (inspectors read reports of checks once or twice a night) and plans of care to guide their use were not developed (see outcome 5). This had been an action at the previous inspection and not fully addressed.

There were no residents with behaviours that challenge in the centre. However, there was no policy in place as required by the Regulations. Inspectors were informed it was in draft format. This had been an issue at the previous inspection also and is further discussed under Outcome 18.

Inspectors read intimate care plans that had been developed for each resident, that were incorporated into their personal plans.

**Judgment:**
Non Compliant - Moderate

### 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:**
Inspectors found that the person in charge and staff had maintained records of all accidents and incidents that had occurred in the centre. These were reviewed by the person in charge and escalated to senior management of the organisation.

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents, within three working days. To date and to the knowledge of inspectors, all relevant incidents had been notified to the Chief Inspector.

**Judgment:**
Compliant

### 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:
Inspectors were satisfied that each resident had opportunities for new experiences, social participation, education, training and that employment was facilitated and supported.

Records reviewed, and discussions held with residents and staff, confirmed residents had a variety of opportunities to engage in education, training and to develop in meaningful ways. These were guided by resident’s own interests and preferences and set out in their personal goals. These included daily tasks like preparing snacks and small meals, to developing personal hobbies. Some residents attended external day services and a number had employment. One resident told inspectors that he was looking forward to commencing a course in creative writing.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Inspectors were not satisfied that residents received appropriate healthcare to meet their assessed needs. There were concerns regarding the identification and assessment of residents identified needs, with non clinical staff carrying out healthcare assessments and providing care outside their scope of practice. Inspectors found the management of falls, wound care, catheter care, epilepsy management and diabetes management required improvement. These matters were discussed with the provider and person in charge during the feedback, who assured inspectors that appropriate action would be taken to meet the health care needs of residents.

Falls prevention and management:
The systems in place to assess and manage falls required significant improvement. Records showed that some residents had repeated unwitnessed falls in 2015. Neurological observations were not completed following these falls. Resident’s records did not detail the care provided to residents following a fall. There was no evidence that
the GP had been notified or reviewed each resident following a fall where a resident had a head injury. There were no measures in place to minimise the risk of future falls or of injury from falling, such as the use of hip protectors or increased supervision. While there were post falls assessments, these were not routinely completed. There was no falls diary or any indication of how many falls a resident had sustained, which would be useful information in planning the service for the residents.

Wound care:
Wound charts had not been fully completed for residents with wounds. There were gaps in residents’ documentation. One resident’s progress notes stated that the resident had a red sacrum, however, there was no care plan to prevent this from developing into a grade 2 pressure sore. The care plan did not guide consistent care as they did not state the frequency of the change of dressing or the type of dressing required. Care staff provided wound care when there was no nurse in the centre. The care staff had not been provided with any training in aseptic technique or wound care. Pressure relieving mattresses were not set correctly and staff were not knowledgeable on the use of pressure relieving equipment.

Epilepsy management:
There was an epilepsy management plan, it did not guide practice. There was no care plan or guidance for staff in relation to the management of a resident during and after seizures, responding to any potential complications or for recording of epileptic activity to guide future interventions. Records read confirmed some staff had received training in the management of residents with epilepsy in 2015.

Diabetes management:
Inspectors noted that the care plan for a resident with insulin dependent diabetes did not contain sufficient detail to guide staff. Goals were not clearly stated or actions to be taken if blood sugar levels fell outside the desired levels.

Dysphagia (swallowing difficulties):
Inspectors were informed that most of the residents had a swallowing difficulty and there was access to external speech and language therapy services. However, there were no risk assessments completed and the care plans did not guide the care for these residents. Records read confirmed staff had received training but not since 2011, therefore were not fully competent in the management of residents with dysphagia. Records showed that a resident with swallowing difficulties was not provided with the altered consistency diets as prescribed by the speech and language therapist which placed this resident at risk.

Catheter care:
The files of two residents were read—one had a supra pubic catheter and another a urinary catheter. Inspectors reviewed in detail the care of one of these residents and found the care plan was not sufficiently detailed to guide care. The staff interviewed could not detail the care of the resident with a urinary catheter. There was some information available on the type of catheter used and when this was due to be changed. Staff had not received training in this area.

Continence care
While some of the residents experienced constipation, the care plans would not guide care and the staff did not monitor residents bowel pattern to respond their changing needs.

Assessment and monitoring:
Inspectors reviewed the records for residents and found that they had access to a general practitioner of their choice, including an out of hour’s service. However, while the GP provided advice to staff over the phone, a nurse was only present every three to four weeks to assess residents. From discussion with care staff and review of residents' medical and care files inspectors formed a view that care staff were not competent to assess, monitor and provide sufficient care to current needs of the residents.

There was no regular weight monitoring carried out by staff. Some records stated weights were last taken in January 2015, there were no weight records on some files read. However, body mass index forms and a malnutrition universal score tools were completed for residents using no or out of date residents weight to identify residents nutritional status. All residents required a weighing scale hoist in order to be weighed. However, the equipment was out of order for a number of weeks, yet no action had been taken to replace or repair it.

There was no follow through and monitoring of care issues and therapeutic blood levels of high risk medication or urinalysis for a resident with a urinary tract infection. While a resident had bloods taken and the sample could not be used, there was no evidence of a repeat blood test, the results or any follow through by the nurse. There were significant gaps of time noted between the entries in the nursing notes, which did not show consistency of care delivered. One residents record showed that the last entry was in April 2015, this stated “staff to monitor closely due to resident's chest infection, urinary tract infection, bowel regime and wellbeing”. Staff did not have the expertise to monitor these healthcare needs and there were no care plans to guide this care.

Another resident's records indicated that the resident was “struggling to breathe” on the 27 March 2015, the next nursing entry was completed on the 08 May 2015 and there was no care plan to guide care.

While clinical risk assessments such as falls, MUST and pressure sore were completed, staff had not had any training in these assessments and they were not being used to inform the care delivered. Care staff also monitored resident’s vital signs, including oxygen saturation, however, they did not have the expertise to respond to residents deteriorating condition in a timely manner. One resident’s records stated that a family member contacted the ambulance when the resident's condition deteriorated. One of the inspectors observed the handover in the morning from night to day staff, the information presented was inaccurate and not comprehensive and would not prepare the staff coming on duty to care for the residents.

While residents had manual handling risk assessments, they were not specific to guide care, such as the use of a handling belt.

Documentation read and information from staff confirmed that residents accessed other health professionals such as the physiotherapy, occupational therapist, dietician and speech and language therapist services when required. There was evidence of referral
and follow-up letters, along with recommendations on the residents' files. However, care plans were not consistently updated to incorporate these advices, which could lead to confusion or incorrect practices by staff, for example, speech and language recommendations for one resident were not up-to-date.

For the most part residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff. Many of the staff ate with residents and there appeared to be positive interactions.

The chef served the residents in the dining room and received feedback on the food. Overall residents expressed satisfaction with the meal however, some residents reported that mealtimes were not of their choosing and based on the routine practices in the centre.

Judgment:
Non Compliant - Major

Outcome 12. Medication Management

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

Theme:
Health and Development

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

Findings:
Inspectors found significant improvements were required in medication management in relation to the procedures around administration of as required (PRN) medications, self-administration assessment and prevention and response to error. The actions from the previous inspection were not fully addressed.

There were a medication management policy. However, it was not sufficiently comprehensive to guide staff practice. There was no policy on the use of PRN (as required medication), pain relief or medication used for the management of status epilepticus. Inspectors found that PRN medications were being administered on a routine basis rather than as PRN and this was not verified by a nurse prior to its administration. There was no pain assessment in place to ascertain the extent of the pain or if the pain relief was effective. The procedures in place for staff in relation to the transcribing, the administration and the process of self administration did not fully guide practice. While records showed that medication was transcribed, this was not completed in line with best practice. The action from the previous inspection and not competed.
Improvements were required in the procedures for self-administration of medication. Some of the residents self-administered their own medications, with encouragement and assistance provided by staff where possible. However, the risk assessment process was not robust and did not ensure risks were assessed and managed. While one resident was described by staff to self-administer medicati on, due to the residents poor manual dexterity, the staff administered the medication. Inspectors found that there was no record maintained when this medication was administered. Each resident had a secure locker in their room to store medications.

A sample of administration and prescription sheets were read by inspectors, and improvements were identified. For example, one residents prescription would not guide practice, while the dose of the residents medication was changed, there was no signature of the doctor who changed this prescription. Another residents prescription would not guide practice, in that two forms of pain relief containing paracetamol were prescribed and it was not clear from the administration record which of these medications had been administered. Staff did not adhere to the codes to be used as documented on the administration record, for example (1) was documented, and staff could not tell inspectors the meaning of this code.

There were systems in place to record incidents of medication errors. However, records showed a significant number noted between February to June 2015- 10 errors had occurred- six of these errors pertained to residents who did not receive their medication. There was no evidence if the resident was reviewed by the GP or if there was any negative outcome for the resident. While medication errors were discussed at the health and safety meeting, there was no learning implemented to reduce the risk of future errors. See outcome 7 (Risk management).

The actions were not taken to respond to the recent medication audit. For example, one resident required larger print on the medication received from pharmacy. This had not been addressed.

There were internal audits of medication practices carried out, which were read by inspectors. However, the audits were not comprehensive as they did not include findings, actions, or corrective measures recommended. The audits were not dated and signed therefore it was not clear what period of time the audits had taken place. They did not identify the issues as reported in this report. See outcome 14 (Governance and Management).

There was a detailed training programme carried out in the administration of medication, and only staff who completed training administered residents medications. However, inspectors were not satisfied that the training programme was completed out in a timely manner to ensure all staff were fully trained. For example, the programme required staff to complete 18 competency assessments with a nurse. However, the nurse was only present in the centre one or two days a month. One staff commenced training in July 2014, had only completed five of the 18 modules to date, and as a result was still unable to administer medications. There were large gaps in the dates staff completed refresher training in this area. This was discussed with the assistant manager and nurse facilitator who provided dates of training for staff who were not up-to-date. This is discussed under Outcome 17. Some of the staff spoken to by inspectors could
not describe the use of the medication, the side effects or the contraindications.

Staff monitored the temperature of the refrigerated medication daily.

All residents medications were regularly reviewed by their GP.

**Judgment:**
Non Compliant - Moderate

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**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:**
Inspectors found that the Statement of Purpose met the requirements of the Regulations. However, it was not fully reflected in practice.

The Statement of Purpose accurately described the type of service and the facilities provided to the residents. It reflected the centre’s aims, ethos and facilities. While it described the support and care needs that the centre was designed to meet, it also stated that a nurse would provide nursing care on a weekly basis. However, health care needs could not be met in the absence of a nurse, who was only present in the centre one to two days per month.

**Judgment:**
Non Compliant - Moderate

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

Findings:
Inspectors found that the management systems in place did not ensure that services provided were safe, appropriate to residents needs, consistently and effectively monitored. The post of person in charge of the centre, was full time and met the requirements of the Regulations. The person in charge was supported by a senior care manager and a regional services manager who reports to the provider nominee who is the Chief Executive Officer.

The roles of the care staff were not clearly set out and understood. Inspectors found that there was a lack of clinical governance in the centre which resulted in poor outcomes for residents. Inspectors identified non compliances in the areas of clinical leadership as outlined in Outcome 7 (risk management), Outcome 11 (healthcare), Outcome 12 (medication management) and and insufficient staffing skill mix as outlined in Outcome 17.

There was no full time nurse overseeing the provision and supervision of clinical practices in the centre. The post of clinical nurse manager in the centre had been vacant since 2014, and while the provider had been actively advertising and holding interviews, the post was not yet filled. However, on a day to day basis, the care assistants were not supervised or supported at all times due to the absence of a nurse to meet residents needs. Inspectors met the clinical education facilitator who provided support to the centre one day every two to three weeks. She outlined her role which was to oversee decision and practices carried out in the previous three weeks. She acknowledged that a nurse was required in the centre.

While there was deputising arrangements in the absence of the person in charge, this was not sufficient to meet the clinical needs of residents in the absence of the clinical nurse manager. The on-call arrangements at the weekends were provided by persons in charge for the service and other services. But not all were clinical staff. Staff reported they would speak to the person in charge before using the on call facility.

Inspectors found that the provider had failed to ensure the arrangements provided sufficient oversight of key areas such as medication management, risk management and healthcare issues as discussed throughout this report.

The system in place to review the safety and quality of care provided required improvement. A number of audits had been completed since the previous inspection and included audits of medication management and health and safety. However, the audits did not bring about change or improvement. There was no evidence of action taken or measures put in place from the audits carried out.

The provider informed inspectors that unannounced visits were carried out of the service
and had commenced the completion of an annual review of the quality and safety of care provided to residents. However, the quality reviews read by inspectors were not comprehensive to bring about improvement. For example, there was no action plan, time-frames and person responsible identified.

**Judgment:**
Non Compliant - Major

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**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:**
There were suitable arrangements in the absence of the person in charge. See outcome 14.

**Judgment:**
Compliant

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**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:**
Inspectors found that this outcome was compliant as the centre was adequately resourced in the number of staff working in the service. However, there are concerns with the lack of staff skill mix meeting the health care needs of residents as reported under outcome 14 (governance and management).
**Judgment:**
Compliant

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

**Theme:**
Responsive Workforce

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

**Findings:**
While the staff were observed to be very caring and passionate about the care they provided, inspectors found that the staff skill mix was not sufficient to meet the needs of residents. Improvements were also required in relation to the training provided to staff to meet the residents needs. The roles and responsibility of volunteers were not clearly set out.

There was no nurse employed by the service on a daily basis. While an agency nurse was employed after the previous inspection, this had ceased. The provider and person in charge outlined the action they were taking to address this deficit, and they were in the process of recruiting a new clinical nurse manager. However, in the interim period nursing support from the clinical education facilitator was only provided two days a month. As demonstrated throughout the report, this was negatively affecting residents health care needs. At the end of the inspection, the person in charge showed inspectors an action plan to address the matter in the interim period. There would be nursing cover provided up to 3 days a week. This was to commence on the 22 June 2015.

Inspectors found that there were six residents with medium dependency, and nine with maximum dependency needs.

Training records outlined the training for all staff. Records showed that mandatory training was provided to staff. However, not all staff did had completed up-to-date refresher training, for example, fire safety, prevention of abuse. There were gaps in other training such as medication management and manual handling. Care assistants were required to make clinical decisions and provided clinical intervention such as the administration of as required medications, had not received training or guidance in this area. While staff received epilepsy training, however there were gaps of four years since the staff received medication management training. Staff had not received training in wound care, falls prevention, and epilepsy training to provide care to residents.
There was a sufficient number of care staff on duty at the weekends to meet residents’ needs. Rosters showed and residents confirmed that there is an adequate number of care staff. Residents said that they felt there were sufficient staff and that staff were very supportive of their care needs.

Staff files were reviewed and they contained the documents as required by Schedule 2 of Regulations. This had been an action at the previous inspection and was completed. There was no agency staff working in the centre.

There were a small number of volunteers in the centre. The files of two volunteer were reviewed however, there were some gaps in place that would not meet the requirements of the Regulations. For example, their role and responsibilities were not set out in writing.

Inspectors read the individual performance reviews of staff and they appeared comprehensive.

**Judgment:**  
Non Compliant - Moderate

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**Outcome 18: Records and documentation**

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

**Theme:**  
Use of Information

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

**Findings:**  
Inspectors found records were accurate and up-to-date, maintained securely and easily retrievable. However, there were gaps in the documentation required to be maintained by Regulations.

The inspector found that the records listed in schedules 2, 3 and 4 of the Regulations were maintained. However, improvements were identified in records required to be kept for residents. For example, there were gaps in the health care information maintained for some residents, which made it unclear to identify if an issue that had been reported
had since been resolved; residents weights were not recorded and dates recorded simply stated a month or a time, and not a date.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. However, they did not fully guide practice, for example, the medication policy and policy on the prevention of abuse. The risk management policy was not implemented in practice.

There was an electronic directory of residents. While there was clear information on each resident maintained, there were gaps identified. For example, the residents home address and their date of admission to the centre.

An up-to-date insurance policy was in place for the centre which included cover for resident’s personal property and accident and injury to residents in compliance with all the requirements of the regulations.

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:

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**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:**
Staff practices observed mealtimes may compromise a resident's dignity and required improvement.

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

**Please state the actions you have taken or are planning to take:**
- The Service Manager has spoken to the staff member concerned and reminded them of the requirement to ensure that all service users are treated with dignity and respect at mealtimes.
- The Service Manager will monitor dining room arrangements, verify each service user’s preferences and record them in their personal plans, we will purchase appropriate furnishings to ensure service user’s needs are met.
- At all handovers staff are being reminded of dignity and respect and to ensure that their daily practices are respectful and dignified, the above action was also itemised on the agenda for the staff meeting on 22/07/2015.

Person/s Responsible:
Service Management Team

**Proposed Timescale:** 05/08/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The supports in place for residents to manage and allay their fears about proposed moves from the centre required improvement.

**Action Required:**
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

**Please state the actions you have taken or are planning to take:**
- Community Transition Coordinators will work with each service user to ascertain any fears which they might have and provide support were required around their future transition from the service - Ongoing
- Each service user will have 1:1 meetings as part of the assessment process and be given every opportunity to discuss any anxiety concerns around transition to the community - Ongoing
- Following this process external supportive services if required will also be sourced.

Person/s Responsible:
Service Manager – Community Transition Coordinators

**Proposed Timescale:** 14/08/2015
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints procedures in place were not centre specific and did not fully meet the requirement of the Regulations

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

**Please state the actions you have taken or are planning to take:**
- Accessible formats for complaints where required will be developed and implemented as required. Adult literacy training has begun for 2 service users who have difficulty reading.
- The complaints procedure and the complaints form will be amended to ensure it is centre specific and that there is a clear appeals procedure. The National complaints procedure outlines the appeals procedure.
- In the interim an accessible format complaints procedure will be distributed within the service – 31/08/2015

Person/s Responsible:
Service Manager with support from National Learning and Development Manager

**Proposed Timescale:** 30/09/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no person nominated to oversee complaints were recorded and responded to.

**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 Regional manager will act as the nominated person for complaints and audit the complaints log on a monthly basis

Person/s Responsible:
Regional Manager - Service Manager
Proposed Timescale: 05/08/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was not centre specific and there was no record of a persons satisfaction with the outcome from a complaint made.

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:
• The Service Manager will review the complaints form and policy to ensure that it is centre specific, to include section for complaints satisfaction feedback in the written version
• Cheshire Irelands online database records service users satisfaction/dissatisfaction regarding all complaints logged.

Person/s Responsible:
Service Quality Officer - Service Management Team

Proposed Timescale: 30/08/2015

Outcome 04: Admissions and Contract for the Provision of Services
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contracts of care reviewed did not outline the services provided for the fees charged.

Action Required:
Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident’s assessed needs and the statement of purpose.

Please state the actions you have taken or are planning to take:
• All contracts of care will be reviewed by the Service Manager to ensure that it includes a clear outline of services provided in line with service users need and statement of purpose.

Person/s Responsible:
Service Manager
Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admission of new residents to the designated centre would not be in line with the Statement of Purpose.

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

Please state the actions you have taken or are planning to take:
• The Service Manager has amended the statement of purpose and A2 registration form which was sent to HIQA on 22/06/2015, to reflect a service user maximum number of 15 persons as discussed with HIQA inspectors.
• There will be no new admissions between now and planned closure of service

Person/s Responsible:
Service Manager and registered provider.

Proposed Timescale: 05/08/2015

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:
A comprehensive assessment of residents social and personal needs was not undertaken

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

Please state the actions you have taken or are planning to take:
• The Service Manager will ensure that a comprehensive assessment of service user’s health, personal and social care needs is carried out. This review will be conducted by the Clinical Nurse Manager 1 with further input from the Clinical Education Facilitator and support from the Service Manager and relevant care support staff.
• The Clinical Nurse Manager 1 will commence on October 12 2015 and they will endeavour to meet each service user on a weekly basis to ensure that care support needs are assessed and appropriate care plans are developed.
• In the interim the RGN will review care support plans on a weekly basis for each service user beginning on August 27th 2015.

Person/s Responsible: Service Manager – Clinical Nurse Manager 1 – Clinical Education Facilitator – RGN

**Proposed Timescale:** 30/11/2015  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
The completion of personal plans for all residents required improvement.

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

**Please state the actions you have taken or are planning to take:**  
• The Service Manager will oversee the development of all personal care plans. Current plans will be reviewed and amended as necessary, initially with the support of the RGN – beginning 27/08/2015. Plans will be further reviewed and amended as necessary following the appointment of the Clinical Nurse Manager 1 on 21/10/2015.  
• All care staff will have completed best possible health care plan development training by 31/08/2015.

Person/s Responsible:  
Service Management Team – Clinical Education Facilitator – RGN – Clinical Nurse Manager 1

**Proposed Timescale:** 31/10/2015  
**Theme:** Effective Services

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

**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:

- In line with the review of service users personal care plans, accessible format plans will be developed and provided to service users.
- As part of the review, service users personal care plans will be shared with Service Users in a format which they can understand.

Person/s Responsible:
Service Management Team – National Training and Development Manager

Proposed Timescale: 30/11/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A review of residents personal plan to assess their effectiveness had not been carried out.

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

Please state the actions you have taken or are planning to take:
- The ongoing reviews of personal care plans by the Clinical Education Facilitator will continue on a monthly basis. This review constitutes two service users per month.
- The RGN will review personal care plans, one per week.
- The Service Manager will implement and conduct an annual review and audit of all service users personal care plans with the support of the Clinical Education Facilitator and Clinical Nurse Manager 1.

Person/s Responsible:
Service Manager – Clinical Education Facilitator – Clinical Nurse Manager 1 - RGN

Proposed Timescale: 31/01/2016

Outcome 06: Safe and suitable premises
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Parts of the designated centre required refurbishment and redecoration.
Parts of the centre were not maintained to a good standard of cleanliness.

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:**
- A comprehensive program of refurbishment and redecoration will be developed and undertaken with immediate effect.
- The program will begin with replacement of bedroom carpets and redecoration of rear corridors beginning 12/08/2015.

Person/s Responsible:
Service Manager

**Proposed Timescale:** 30/11/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The there was no system to ensure that equipment was maintained and in working order.

**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 Service Manager has purchased a new weighing scales to ensure that care support needs of service users in relation to their weight can be assessed and monitored.
- The Service Manager will review and strengthen the equipment maintenance plan and ensure all repairs are carried out in a timely manner. This review has commenced on 27/07/2015 and will be reviewed on a monthly basis.

Person/s Responsible:
Service Manager

Proposed Timescale: 31/08/2015 and ongoing

**Proposed Timescale: 31/08/2015**

**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:
The risk management policy was not implemented in practice to identify and assess
risks, including those outlined in the report.

**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:**
- We will undertake a review of risk management within the service and identify and assess levels of risk and provide an implementation plan to safeguard against identified risks.
- The review will be conducted by the Service Manager in conjunction with the Health and Safety Officer and will commence on the week beginning 11/08/2015

Person/s Responsible:
Health & Safety Officer - Service Manager

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**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The there systems in place to assess and monitor risk in the centre required improvement.

**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 Service Manager will ensure that the review of risk management will include the requirement to respond timeously to emergencies with clear written instructions provided to all staff in relation to emergency responses.
- The Service Manager will review the emergency plan and responses outlined. These practices will be discussed as a standing agenda item on all Health & Safety Committee Meetings.
- An action plan will be developed to clarify emergency response requirements for all staff and distributed in a written format

Person/s Responsible:
Health & Safety Officer - Service Manager

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**Proposed Timescale:** 31/08/2015

**Theme:** Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Incidents that occurred in the centre were not fully investigated and there was evidence of improvement and change brought about.

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

**Please state the actions you have taken or are planning to take:**
- The Service Manager will ensure that all adverse event incidents are reviewed on a monthly basis and appropriate actions are outlined and recorded including signed witness statements to ensure the risk control measures are proportional to the risks identified in the report.
- The Service Manager will ensure that measures agreed are discussed with service users and or representatives to ensure any impact on life quality is minimised.

Person/s Responsible:
Service Manager

**Proposed Timescale:** 01/09/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Infection control policies and procedures required improvement.

**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 Service Manager will ensure that all staff including domestic staff will have appropriate infection control training.
- A review of each staff members infection control training will be carried out by the Service Manager by 31/08/2015.
- Areas where gaps are identified will be addressed by 30/09/2015.
- The Service Manager will monitor Infection control practices within the service. Any issues identified will be tabled at regular Health and Safety Meetings and as part of performance management meetings with individual staff members.

Person/s Responsible:
Service Manager – Health and Safety Committee
Proposed Timescale: 31/10/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were deficits in the provision of fire doors to contain fire in the centre.

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

Please state the actions you have taken or are planning to take:
- The Service Manager has met with Cheshire Irelands Health and Safety Officer who has ensured that the fire doors within the building meet regulatory requirements and that all bedroom doors are fire resistant
- As part of this meeting the Service Manager has confirmed with Health and Safety Officer that the kitchen doors are fire doors.
- Cheshire Irelands Health and Safety Officer will conduct a review of fire safety within the building to include fire doors.
- The Health and Safety Officer will review the requirement for fire doors in the dining area and an action plan will be developed based on this review.

Person/s Responsible:
Cheshire Irelands Health & Safety Officer - Service Manager

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Proposed Timescale: 30/10/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was documentary evidence that staff did not follow the centre's fire safety guidelines when the fire alarm was activated.

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

Please state the actions you have taken or are planning to take:
- Fire safety guidelines have been reviewed by health and safety committee following a specific incident, interim guidelines were communicated to all staff at handovers and by memorandum and emergency protocol has since been revised. This communication makes clear the requirement to follow fire safety guidelines on all occasions once the alarm system has been activated.
• Fire safety will be included as an agenda item at all Health & Safety Committee meetings.
• An evening information meeting was held on 15/07/2015 which included a member of the Fire Service. This meeting was attended by staff and service users.
• We will review the number and type of fire drills carried out within the service. As an interim measure fire drills will be carried out on a two weekly basis to ensure adherence to fire safety guidelines.

Person/s Responsible:
Cheshire Irelands Health & Safety Officer - Service Manager

Proposed Timescale: 31/08/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no reports of fire equipment testing available to ascertain if equipment was serviced on a regular basis.

Action Required:
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
• As per Cheshire Irelands servicing agreement with Sharp Security all emergency lighting and fire equipment in Richmond Cheshire House has been tested and repaired as required. An up to date certification from Sharp Security has been supplied and sent to HIQA following inspection.
• Cheshire Irelands Health & Safety Officer will conduct a review of fire testing equipment by 31/08/2015 and will monitor this on an ongoing basis.

Person/s Responsible:
Service Manager – Cheshire Irelands Health & Safety Officer

Proposed Timescale: 31/08/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Three staff did not have up-to-date fire safety training as required by Regulations.

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

Please state the actions you have taken or are planning to take:
• In relation to the three staff identified, two staff have undergone the required training on 29/07/2015.
• The one remaining member of staff who has not received training will attend the next training course before 31/08/2015.

Person/s Responsible:
Service Manager – National Learning and Development Manager

Proposed Timescale: 31/08/2015

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The alternatives to bedrails were not considered in line with the National Policy.

The risk assessment for the use of bedrails was not robust and required revision.

There was irregular checks of bedrails when in use.

Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
• We will revise the risk assessments in relation to bedrails and falls and implement a monthly check of all bed rails in use.
• The Service Manager in conjunction with the RGN will review the risk assessments in relation to service user falls beginning on 27/07/2015 and continue on a weekly basis to ensure that risk is minimised.
• We will ensure that where bedrails are in use all alternatives are explored

Person/s Responsible:
Service Manager - RGN

Proposed Timescale: 31/08/2015
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The procedures for the reporting and investigation of suspicions and allegations of abuse required improvement.

**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:**
- As an ongoing practice we will ensure all investigations of suspicions and allegation of abuse will include witness statements.
- The Manager and Assistant Manager will attend training around relevant abuse investigations.
- Reports will be reviewed by the Regional Manager on a monthly basis commencing 17/08/2015.

Person/s Responsible:
Service Manager – Regional Manager

**Proposed Timescale:** 30/09/2015

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Appropriate health care was not provided to residents in the areas such as falls management, wound care, catheter care, nutrition and management of diabetes.

Health care assessments were completed by non clinical staff with no training in their completion.

Health care plans were not comprehensive to guide care to be delivered to staff.

Health care plans did not consistently include the most up-to-date allied health professional recommendations.

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

**Please state the actions you have taken or are planning to take:**
- As an interim measure since 20/06/2015 whilst finalising recruitment of permanent CNM1, we have a used CNM2 x 2 days per week, a Clinical Education Facilitator x 1 day per week. From 27/07/2015 we have recruited a temporary RGN x 5 days per week to cover the interim period until October 2015 when our new CNM1 starts.
- All healthcare assessments and plans including falls management, wound care,
catheter care, nutrition and diabetic care is currently being reviewed for each service user by the RGN beginning with those deemed at most risk. These reviews are being implemented on a 1 x service user per week basis.

- This work will be continued by the CNM1 from 12/10/2015.

Person/s Responsible:
- Service Manager – RGN – Clinical Education Facilitator – Clinical Nurse Manager 1

**Proposed Timescale:** 18/12/2015  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Changes to residents diets were not adequately communicated to the kitchen staff.

**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 Service Manager will review changes to service user diets and ensure a robust communication plan with the kitchen staff is implemented and maintained commencing 20/07/2015.  
- All changes to service user diets will be provided in a written format to the kitchen staff and reviewed in bi-weekly meetings between the kitchen staff and Service Manager.

Person/s Responsible:  
- Service Manager

**Proposed Timescale:** 31/08/2015

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**Outcome 12. Medication Management**  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The procedures for prescribing and administration of medications required improvement.

**Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.
Please state the actions you have taken or are planning to take:

- We will review procedures for prescribing and administration of medication with a particular emphasis on PRN medications and pain assessments.
- The RGN will liaise with service user GPs to ensure that all medications are up to date and relevant prescription sheets are accurate.
- Each service user's medication will be reviewed on a 2 x service users per week basis by the RGN and Service Management Team.
- New medication management training is being provided to all staff and will be completed by 21/07/2015, this training will then require additional clinical sign-offs.
- We will continue with a program of medication audits (2 per month)

Person/s Responsible: Service Manager – Clinical Education Facilitator – RGN - CNM1

Proposed Timescale: 30/09/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system of assessing residents who self administer medication required improvement.

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

Please state the actions you have taken or are planning to take:
- The RGN will review the risk assessments currently in place for service users who self-medicate beginning 27/07/2015. This review will be completed by 31/08/2015.
- This will be reviewed on an ongoing basis by the RGN and CNM1

Person/s Responsible:
Service Manager – RGN – Clinical Education Facilitator – CNM1

Proposed Timescale: 31/08/2015

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:
The centre's practices do not reflect the statement of purpose.

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

Please state the actions you have taken or are planning to take:
• We have advised HIQA of interim use of Clinical Nurse Manager along with offer of employment for permanent full-time Clinical Nurse Manager 1 beginning on 12/10/2015
• The Service Manager has advised HIQA of the appointment of a temporary RGN from 27/07/2015 on a full time basis to cover the interim period until the commencement of the CNM1.
• The statement of purpose was reviewed and resubmitted to HIQA during the course of the inspections. Amendments as outlined by the inspector during the course of inspections were included in this resubmission 16/06/2015.
• The Service Manager will review the statement of purpose within a 6 month period against the regulatory requirements.

Person/s Responsible:
Service Manager

Proposed Timescale: 31/08/2015

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:
The management systems in place did not ensure that services provided are safe, appropriate to residents' needs, consistent and effectively monitored.

There was a lack of clinical governance in the centre.

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 Service Manager has advised HIQA of the recruitment of an RGN 27/07/2015 along with the offer of employment to a permanent full-time Clinical Nurse Manager 12/10/2015
• Whilst finalising recruitment of a permanent CNM1, the nursing situation within the organisation is as follows:-
  • We have a full-time RGN x 5 days per week
  • A Clinical Education Facilitator is available within the service 1 day per week

Person/s Responsible:
Service Manager
Proposed Timescale: 31/08/2015
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the safety and quality of the service.

Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
- A quality and safety audit will be carried out by 01/10/2015
- The audit will be written by a member of staff external to the service.
- The audit report will be reviewed and approved by the Registered Provider prior to its circulation
- An action plan will be developed by the Service Manager to ensure any areas of non-compliance are addressed.

Person/s Responsible:
Service Manager – Registered Provider

Proposed Timescale: 01/10/2015

Outcome 17: Workforce
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an inadequate staff skill mix to meet the assessed needs of residents in the centre.

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:
- Whilst finalising recruitment of permanent CNM1, we have used a CNM2 x 2 days per week and a Clinical Education Facilitator x 1 day per week.
- We have recruited a full-time RGN commencing on 27/07/2015 for a three month period.
- New Clinical Nurse Manager 1 is scheduled to commence on 12/10/2015
**Person/s Responsible:**
Service Manager

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<th><strong>Proposed Timescale:</strong> 05/08/2015</th>
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<td><strong>Theme:</strong> Responsive Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff had not been provided with refresher training in mandatory areas such as, fire safety, prevention of abuse and movement and handling.

Staff were not provided with training to meet the identified health care needs of residents, for example, woundcare, falls prevention, and epilepsy management.

**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:**
- We will review staff training requirements in line with identified service user healthcare needs.
- We will ensure that Senior Care Workers have completed training in woundcare, falls management and epilepsy by end of September 2015
- We will develop a programme for all staff to receive up to date training in prevention of abuse and movement and handling (currently 7 staff require refresher training which will be completed by 31/10/2015)

Person/s Responsible:
Service Manager – National Learning and Development Manager

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<th><strong>Proposed Timescale:</strong> 30/11/2015</th>
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<td><strong>Theme:</strong> Responsive Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no written outline of volunteers roles and responsibilities.

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

**Please state the actions you have taken or are planning to take:**
- The Service Manager will provide a written centre specific policy for the role and
responsibilities of volunteers by 31/08/2015.
  • The policy will be implemented and reviewed by the Service Manager and communicated to all volunteers and staff and will form part of all volunteers induction programme.
  • This policy will be reviewed on a 6 monthly basis.

Person/s Responsible:
Service Manager

Proposed Timescale: 30/09/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy was not implemented in practice.

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
  • Healthcare information for all service users will be reviewed and updated to ensure service user safety
  • All service users files will be reviewed beginning on 27/07/2015 to ensure that relevant healthcare information is accurately recorded and updated. This will be conducted on a weekly basis (2 x service users per week)
  • Training in report writing will be rolled out to care support staff beginning 01/09/2015 with an estimated completion date of 30/11/2015.
  • Healthcare records will be audited by the Service Manager and RGN/CNM1 on a monthly basis commencing 01/09/2015.

Person/s Responsible:
Service Manager – CNM1 – RGN - Clinical Education Facilitator – National Learning and Development Manager

Proposed Timescale: 30/11/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies in place did not consistently guide staff practice. For example, medication and
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:
• We will review policy implementation in relation to medication and prevention of abuse and ensure that they are relevant to service user needs. This will commence on 27/07/2015 and will be rolled out over a five month period.

Person/s Responsible:
Service Manager – RGN - Clinical Nurse Manager 1 – Clinical Education Facilitator – Regional Manager

Proposed Timescale: 31/12/2015
Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were some gaps in the information required to be maintained in the directory of residents.

Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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 current National Service User Database will be reviewed to ensure it meets all regulatory requirements.
• Gaps in the directory of service user highlighted by HIQA ie admission dates and previous addresses have been added to the Database.

Person/s Responsible:
Service Manager – National Clinical Risk Manager

Proposed Timescale: 31/08/2015
Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Full and complete records of residents were not maintained as outlined in the report.
**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:**
- Service users records will be reviewed by the Service Management Team beginning on 05/08/2015 to ensure that they meet the appropriate regulations and are accurate and updated.
- Records will be amended to ensure that they comply with the regulatory requirement by 30/11/2015.

Person/s Responsible:
Service Manager

**Proposed Timescale:** 30/11/2015