

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Services Ireland
<b>Centre ID:</b>	OSV-0004877
<b>Centre county:</b>	Clare
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services Ireland
<b>Provider Nominee:</b>	Eamon Loughrey
<b>Lead inspector:</b>	Louisa Power
<b>Support inspector(s):</b>	Michelle O'Connor (Day 1 only)
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	7
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
22 October 2015 09:00	22 October 2015 17:30
23 October 2015 09:00	23 October 2015 15:45

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

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

**Summary of findings from this inspection**

The inspection was an announced registration inspection and took place over two days. An inspection had taken place in September 2014 in one of the service units. As part of the inspection process, inspectors met with the provider nominee, person in charge, persons participating in management, residents, relatives and staff members. Inspectors observed practices and reviewed documentation such as personal plans, medical records, policies and procedures. The documentation submitted by the provider as part of the application process was submitted in a timely and precise manner and was examined prior to the inspection. Questionnaires completed by residents and their representatives were also reviewed; the feedback

was positive and is referenced in the body of the report.

Overall, inspectors found that residents received support that was individualised and person centred; their social and health care needs were met. A good rapport between residents and staff was evident throughout the inspection and staff supported residents in a respectful and dignified manner. Residents reported to be well-cared for, happy and content. Residents were supported to participate in meaningful activities, appropriate to their individual preferences and abilities; residents' independence and ability to communicate were maximised and residents were supported to develop and maintain family and community links. Residents were consulted with and participated in decisions about their care. Access to advocacy services was provided.

A judgment of major non-compliance was made in relation to Outcome 9: Notification of incidents. A notification had not been submitted within three working days to the Chief Inspector in relation to a potential safeguarding incident. A number of additional improvements were identified to enhance the substantive evidence of good practice and to comply with the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. This included a review of fire precautions and procedures to ensure that they were adequate to meet the needs of residents. The additional required improvements are set out in detail in the action plan at the end of this report and include:

- medicines management
- review of documentation to ensure accuracy and completeness
- assessment and personal planning practices
- multi-disciplinary input when planning for restrictions.

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

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

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Residents and relatives with whom inspectors spoke stated that they felt safe and spoke positively about their care and the consideration they received. Residents and relatives outlined that the staff were readily available to them if they had any concerns. Interaction between residents and staff was observed and inspectors noted staff promoted residents' dignity and maximised their independence, while also being respectful when providing assistance.

Residents and their representatives were actively involved in the centre. Residents were consulted about, and participated in, decisions about their care and the organisation of the centre. Advocacy discussions with residents take place on a monthly basis. Minutes of local self-advocacy meetings attended by a representative from the centre were made available to inspectors. The meetings took place at least six times per year and issues such as social events and development of information in easy read format were discussed. Representatives from the local advocacy group attended the regional advocacy group who meet the local management teams at least three times per year.

Staff were observed to provide residents with choice and control by facilitating residents' individual preferences in relation to their daily routine, meals, assisting residents in personalising their bedrooms and their choice of activities. Residents were encouraged to choose their activities for the day. However, inspectors noted that residents were not always afforded the opportunity to provide consent for decisions about their care and support. In some circumstances, parents provided consent for residents in relation to the provision of intimate care and administration of medicines.

Inspectors observed that residents were supported in a dignified and respectful manner. Residents' capacity to exercise personal independence was promoted. For example, residents' ability to perform tasks in relation to personal hygiene and dressing was identified and residents were encouraged to perform these tasks.

Residents were encouraged to maintain their own privacy and dignity. Each resident had their own bedroom and staff were observed to knock before entering. Suitable locks were provided on the doors of toilets and sanitary facilities. Where sanitary facilities were shared, intimate care plans did not take into account the measures to promote the privacy and dignity of residents during personal care in this context.

Residents' personal communications were respected and residents had access to a telephone. Some residents had access to a personal mobile telephone. Inspectors observed that residents and their visitors were given space to chat freely.

There was a complaints policy which was also available in an accessible format and had been reviewed in June 2015. The policy was displayed throughout the centre. The complaints policy identified the nominated complaints officer and also included an independent appeals process as required by legislation.

Inspectors reviewed the complaints log detailing the investigation, responses and outcome of any complaints. The complaints form had been recently updated to include whether the complainant was satisfied. However, it was noted that the satisfaction of the complainant was not recorded for informal complaints. This was discussed with the person in charge who amended the complaints log on the first day of the inspection. The investigation undertaken in response to complaints was thorough, comprehensive and prompt. The actions taken by the person in charge were adequate.

Residents were encouraged and facilitated to retain control over their own possessions. There was adequate space provided for storage of personal possessions. Records in relation to residents' valuables were maintained and updated regularly in line with the centre-specific policy reviewed in September 2014. Residents were supported and encouraged to do their own laundry with adequate facilities available. Residents had easy access to personal monies and where possible control over their own financial affairs in accordance with their wishes. Money competency assessments were completed annually for each resident which outlined the supports and training needs, if any, required.

Residents are facilitated to exercise their civil, political and religious rights. Easy read information was provided to residents in relation to their rights. Residents were afforded the opportunity to vote. Residents were supported to attend religious services in line with their wishes.

**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:**

Residents were facilitated to communicate in line with the centre-specific policy, reviewed in April 2015. Residents had diverse communication needs; some residents did not use verbal communication.

A communication domain was included in the discovery document which ascertained the individual resident's preferred method of communication and supports required. Personal care plans viewed by an inspector outlined individual requirements, interventions and goals in relation to effective communication. Staff demonstrated an awareness of the different communication needs of residents and implemented the information contained in personal care plans. Residents had access to specialist input from speech and language therapists who completed comprehensive communication assessments. Interventions recommended following these communication assessments had been incorporated into residents' personal plans. For example, staff were knowledgeable in relation to the meaning of a resident's signs and gestures and used communication visual aids and cues to ensure that the resident could communicate effectively. Comprehensive communication passports had been developed in line with residents' needs. Residents were facilitated to access assistive technology, aids and appliances, including tablet technology, to promote their full communication capabilities.

The centre was part of the local community. Some residents accessed employment and training in the local area. Residents used local amenities such as leisure centre, golf club, church and restaurants. Residents were supported by staff to shop in local stores. Volunteering opportunities were sourced in the local area. Residents were supported to join local sporting clubs. Inspectors observed that residents had access to radio, television, newspapers and information on local events.

**Judgment:**

Compliant

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

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

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

Positive relationships between residents and family members were supported. Many residents spent weekends and holidays with family. Residents were facilitated to keep in regular contact with family through telephone calls and inspectors observed that family members were made welcome when visiting. There were adequate facilities for each resident to receive visitors and a number of areas were available if residents wished to meet visitors in private.

Staff stated and inspectors saw that families were kept informed of residents' well being on an ongoing basis, in line with residents' wishes. Records confirmed that families and residents attended personal planning meetings and reviews in accordance with the wishes of the resident.

An inspector reviewed the policy in relation to visitors, which had been reviewed in April 2014. The policy outlined that a warm welcome was extended to all visitors except when requested by the resident or when the visit or timing of the visit is deemed to pose a risk.

A day service was provided for all residents; a flexible and tailored day service was provided for some residents within the centre whilst other residents attended a day service externally. Transport was provided for residents who attended an external day service. An inspector reviewed residents' activity schedules and saw that residents were facilitated to participate in a range of activities in the local and wider community including meals out, Special Olympics training and events, availing of gym and leisure facilities, attending sporting events and socialising. Some residents had attained employment, training and volunteering opportunities in the local and wider community. Residents were supported to shop and use services locally.

**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:**

The policy on admissions, transfers and discharge of residents, which had been reviewed in February 2014, was made available to inspectors. The policy outlined the transparent criteria for admission and took account of the need to protect residents from abuse by their peers. Residents' admissions were seen to be in line with the statement of purpose.

A written contract was in place which dealt with the support, care and welfare of the resident in the centre and included details of the services to be provided. The fees and additional charges were included. The contract was also available in an accessible version.

**Judgment:**

Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

A sample of residents' plans was reviewed by an inspector. A discovery document was used to assess the health, personal, social care and support needs of the resident annually and the information contained was individualised and person centred. The discovery document formed the basis of an individual personal plan (IPP). An IPP had been developed for each resident which included a comprehensive life story, family support network and important background information. The IPP outlined residents' needs in many areas including healthcare, education, lifelong learning and employment support services, social services, personal support network, transport and mobility. The resident and representatives were consulted with and participated in the development of the personal plan.

Goals and objectives were clearly outlined. There was evidence of resident involvement in agreeing/setting these goals. There was also evidence that individual goals were achieved. A number of goals were true aspirations and would improve the residents' quality of life such as attending the leisure centre independently, visiting a job coach and voting in upcoming elections. However, the inspector noted that a number of the goals outlined focussed on continuing to support the residents in activities of daily living and meeting healthcare needs. The person responsible for supporting the resident in pursuing these goals was not always clearly identified. Some of the goals outlined were not specific. For example, goals outlined for residents included providing support to participate in the local community and build relationships or to implement recommendations of the multidisciplinary team without outlining the recommendations. The lack of definite goals could lead to residents not maximising their personal development. The PCP was made available to each resident in an accessible format in line with their needs.

The PCP was subject to a review on an annual basis or more frequently if circumstances change. The inspector saw evidence that the review was carried out with the maximum participation of the resident. The review did assess the effectiveness of the plan and reviewed the goals/aspirations that had been identified. There was evidence of multidisciplinary team involvement including physiotherapy, speech and language therapy, general practitioner (GP), occupational therapy, psychiatry and psychology services. There was evidence that the recommendations and input of the multidisciplinary team were reviewed and discussed at the annual review. Changes in circumstances and new developments were included in the PCP and amendments were made as appropriate.

A booklet was available for staff to record relevant and important information in the event of a resident being transferred to hospital. The booklet was completed in advance and contained comprehensive information in relation to the needs of the resident including communication, personal care and healthcare.

**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:**

The centre consisted of three two-storey houses; two of the houses were located in the suburbs of Ennis and the remaining house was located in a village approximately 8 kilometres outside Ennis. One of the service units had an annex one-bedroom apartment to the rear which accommodated one resident. Access to the apartment was via a separate front door and also through the main premises if required. All service units were easily accessible, bright, well ventilated, had central heating and decorated to an adequate standard. The service units were homely and decorated in a tasteful manner with co-ordinated soft furnishings. Both communal and personal areas were personalised with photographs and personal memorabilia. The décor, design and layout were compatible with the aims of the statement of purpose. An assessment had been completed in one of the service units by an occupational therapist in October 2015 who recommended that a number of adaptations be made and equipment be provided in order to ensure that a resident's individual needs were met. The provider has provided an assurance that these recommendations will be implemented in a timely manner.

The centre was clean, suitably decorated and well maintained. There was suitable heating, lighting and ventilation and the centre was free from major hazards. There were suitable and sufficient furnishings, fixtures and fittings.

There were adequate showers and toilets to meet the needs and abilities of the residents. There were adequate sitting, recreational and dining space separate to the residents' private accommodation and separate communal areas, which allowed for a separation of functions. A separate kitchen area was available in each service unit with suitable and sufficient cookery facilities, kitchen equipment and tableware. Inspectors observed that residents were supported to participate in preparing meals. A dining area was located within each kitchen. Appropriate laundry facilities were provided and residents were supported to do their laundry according to their wishes.

Residents had all personalised their rooms with photographs of family and friends and personal memorabilia. Ample storage space was provided for residents' personal use. Apart from the residents' own bedrooms, there were options for residents to spend time alone if they wished with a number of communal areas available.

There were suitable accessible grounds/outside areas in each service unit with suitable garden seating and tables provided for residents' use. The grounds were kept safe, tidy and attractive.

**Judgment:**

Compliant

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

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

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

**Findings:**

Overall, the provider was committed to protecting and promoting the health and safety of the all in the centre. A proactive approach had been implemented in relation to risk management. However, some improvement was required in relation to fire safety and the assessment of risks.

There was a health and safety statement in place which was last reviewed in September 2014. This outlined general aims and objectives in relation to health and safety within the centre. The health and safety statement was augmented by a risk management policy, last reviewed in November 2014. The risk management policy outlined broad safety statements, the procedures for recording, reporting and investigation of accidents, a range of centre-specific risk assessments, an assessment of each risk and the controls identified as necessary to reduce each risk. The risks identified specifically in the Regulations were included in the risk register. There was evidence that risk assessments had been implemented in practice and were kept under continual review. However, it was noted that not all risks within the centre had been assessed. For example, open-flame candles were seen to be in use throughout the centre but a risk assessment had not been completed to ensure that the controls outlined in the candle safety advice document were adequate.

A comprehensive emergency plan was in place which covered events such as natural disasters and utility failure. Provision was made to cover an event where the centre may be uninhabitable.

An inspector reviewed a sample of incident forms and saw that accidents and incidents were identified, reported on an incident form and there were arrangements in place for investigating and learning from accidents. The inspector noted that the improvements identified were implemented in a timely fashion. A quarterly review was completed of incident forms which analysed any patterns and reviewed the effectiveness of preventative actions

A quarterly health and safety audit was completed, most recently in September 2015, which included a review of fire safety, first aid, lighting, equipment, electricity, chemical safety and manual handling. The audit identified pertinent deficiencies and actions emanating from the audit were completed in a timely manner.

Suitable fire equipment was provided throughout the centre. Fire safety equipment was to be serviced on an annual basis but inspectors noted that the equipment in one service unit had not been serviced in the previous 12 months. This was brought to the attention of the person in charge on the first day of inspection and the equipment was serviced before the end of the inspection. There was an adequate means of escape. Fire exits were unobstructed. The clear procedure for safe evacuation in event of fire was displayed in a number of areas. A fire engineer's report had been completed for all service units and actions had been completed. A category L1 fire system had been installed in July 2015 in each service unit. The panel was serviced on a quarterly basis.

Emergency lighting had been installed in July 2015 and serviced in October 2015. Records of daily and monthly fire checks were kept. These checks included inspection of the fire panel, escape routes, emergency lighting and evacuation procedure. However, some gaps were evident in the completion of this documentation.

Staff demonstrated good knowledge in relation to fire safety and the procedure to follow in event of a fire and the training matrix made available confirmed that all staff had received mandatory fire training. Fire drills took place at least every six months and a detailed description of the fire drill, duration, participants and any issues identified were reviewed by an inspector. However, documentation indicated that a fire drill had not been completed to simulate a night-time situation where only 1 staff member would be on sleepover duty. This was confirmed by the person in charge.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents and had been updated regularly. However, it was noted that PEEPs were not reviewed when difficulties were encountered during fire drills, e.g. a resident refusing to leave or returning to centre before 'all clear' was given, in conjunction with suitably qualified persons. Therefore, there was a risk that the evacuation plan may fail which could prove catastrophic.

Individualised risk assessments were completed for residents who smoke and there was evidence of the implementation of the identified controls. Adequate controls were in place to mitigate the risk. Residents had agreed not to smoke inside and to leave lighters downstairs when retiring at night. Appropriate safe disposal was in place at the designated smoking area.

A policy was in place for the prevention and control of infection, reviewed in September 2014, which was comprehensive and would effectively guide staff. The centre was visibly clean, personal protective equipment (PPE) was provided and there were adequate hand sanitising and washing facilities. Hand hygiene and infection control training had been completed by all staff.

The training matrix indicated that a staff member had not completed training in moving and handling of residents; this is covered in outcome 18.

Vehicles were available and records reviewed by an inspector confirmed that the vehicles were roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

**Judgment:**  
Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

Systems were in place to protect residents from being harmed or suffering abuse. A restraint-free environment was promoted. Residents were provided with emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges. Improvements were required to ensure that all allegations, suspicion or disclosures of abuse are managed appropriately and that assessments prior to the use of restrictive practices are multi-disciplinary in nature.

There was a policy and procedure in place in relation to the safeguarding of vulnerable adults, reviewed in February 2015. The policy identified the designated safeguarding officer and their deputy. The policy and procedure were comprehensive, evidence based and would effectively guide staff in the reporting and investigation of incidents, allegations or suspicions of abuse. The policy included a reporting pathway if the allegation was made against a member of the management team. The policy was also available in an accessible format.

An intimate care policy had been reviewed in July 2012 and outlined how residents and staff were protected. Each resident had a personal care plan which was reviewed on a regular basis. The plan outlined in detail the supports required, resident's preference in relation to the gender of staff delivering personal care.

Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff with whom inspectors spoke were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom inspectors spoke confirmed that they felt safe in the centre and that they knew who to talk to if they needed to report any concerns of abuse.

The provider and person in charge monitored the systems in place to protect residents and ensure that there are no barriers to staff or residents disclosing abuse. A robust recruitment and selection procedure was implemented, all staff received ongoing training in understanding abuse and senior staff stated that there was an open culture of reporting within the organisation.

Records were provided that confirmed that any incidents, allegations and suspicions of abuse had been recorded and investigated. The appropriate safeguards had been put in place to protect residents. However, the Chief Inspector had not been notified within three working days where there had been a suspicion of abuse; this is further outlined in Outcome 9: Notifications of incidents.

A centre-specific policy was in place to support residents with behaviour that challenges, reviewed in October 2014. The policy was comprehensive and focussed on understanding the function of the behaviour, responding and communicating appropriately and identifying triggers for the behaviour. Training records confirmed that training was provided to staff in the management of behaviour that is challenging including de-escalation and intervention techniques.

An inspector reviewed a selection of plans for support behaviour that challenges and spoke with staff. Residents and their representatives were involved in discussions and reviews that had been arranged to support residents to manage their own behaviour. Clear proactive and reactive strategies were in place to support residents to manage their own behaviour and staff were able to describe the strategies in use.

Environmental restraint was in use; its use was guided by a centre-specific policy and followed an appropriate assessment. The policy had been reviewed in October 2014, was comprehensive and was in line with evidence-based practice. A risk balance tool was used prior to the use of environmental restraint, less restrictive alternatives were considered and signed consent from residents was secured where possible. However, multi-disciplinary input had not been sought.

**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 noted that a comprehensive record of all incidents was maintained. A robust process was in place to ensure that notifications to the Authority were made in line with the requirements of the Regulations. However, as previously outlined in outcome 8: Safeguarding and safety, a notification relating to Regulation 31(1)(f) had not been submitted to the Chief Inspector within three working days.

**Judgment:**  
Non Compliant - Major

**Outcome 10. General Welfare and Development**

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

**Theme:**  
Health and Development

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

No actions were required from the previous inspection.

**Findings:**

Residents' opportunities for new experiences, social participation, education, training and employment were facilitated and supported. Improvements were required to ensure that assessments met residents' educational/employment/training needs.

The policy on access to education, training and development was made available to inspectors and had been reviewed in October 2014. A day service was provided for all residents; a flexible and tailored day service was provided for some residents within the centre whilst other residents attended a day service externally. Some residents attended education, training and volunteering opportunities in the local community and support was provided in relation to travel arrangements.

Activities within the day service included information technology, arts and crafts, music, literacy, sport and dancing. Residents were supported to use local services such as leisure, gym and sports facilities. Some residents volunteered or had attained work experience in the local community. A resident had set up a window cleaning business.

Residents' educational achievements were valued and proactively supported by the practices in the centre. Residents were supported to attend courses which led to a Quality and Qualifications Ireland (QQI) award.

Information was gathered in the discovery document to establish each resident's education, training and employment goals. The information included in some of the discovery documents reviewed lacked detail and was not sufficient to perform a robust assessment to ensure that appropriate opportunities are made available in relation to education, training and development.

**Judgment:**  
Substantially 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:**

Residents' healthcare needs were met through timely access to health care services and appropriate treatment and therapies. A medical practitioner of their choice was available to each resident and an "out of hours" service was available if required. Access to a medical practitioner was facilitated regularly. Medical advice and consultation in the event of clinical deterioration was seen to be sought in a timely fashion. There was clear evidence that there treatment was recommended and agreed by residents, this treatment was facilitated. Residents' right to refuse medical treatment was respected.

Where referrals were made to specialist services or consultants, staff supported residents to attend appointments. In line with their needs, residents had ongoing access to allied healthcare professionals including dental, speech and language, optical, psychology and audiology.

The management of epilepsy was in line with evidence based practice. A comprehensive record of seizure including date, time, type of seizure, duration and recovery was maintained. Residents were supported to visit the neurology clinic regularly and the appropriate recommendations were implemented. A personalised management plan was in place which guided staff in the administration of buccal midazolam and all staff had received appropriate training. However, the information contained in a resident's communication passport did not reflect the management plan signed by a member of the specialist neurology team as regards the timing of administration of buccal midazolam.

A bereavement and end of life policy was made available to inspectors which described the procedure to be followed in the event of a sudden or unexpected death. The policy outlined that a proactive approach was to be taken in order to ascertain residents' views in relation to loss, death, dying and end of life. An inspector reviewed a sample of residents' records and saw that a comprehensive end of life had been developed for some residents. The plan was developed in consultation with residents and their representatives and outlined the resident's wishes in relation to support at end of life and funeral arrangements. However, a plan had not been completed for all residents capturing residents' wishes in relation to care at times of illness or end of life. Therefore, information would not be available to guide staff in meeting all residents' needs whilst respecting their dignity, autonomy, rights and wishes.

Residents were encouraged and enabled to make healthy living choices in relation to exercise, smoking cessation, weight control and healthy eating. Residents' weights were monitored on a monthly basis and residents' weights were stable and within a healthy range. A process was in place to make referrals to a dietician and speech and language therapist, when appropriate. Residents were encouraged to be active through attending the gym, surfing, swimming, bowling and walking.

Residents were encouraged to be involved in the preparation and cooking each meal. Staff with whom inspectors spoke confirmed that a choice was provided to residents for all meals. The meals outlined by staff and residents were nutritious and varied. There were ample supplies and choice of fresh food available for the preparation of meals. Outside of set mealtimes, residents had access to a selection of refreshments and snacks and residents were encouraged to prepare their own refreshments and snacks. There was adequate provision for residents to store food in hygienic conditions.

Residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents' needs was available in an easy read format.

**Judgment:**

Substantially Compliant

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

Medicines for residents were supplied by local community pharmacies. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. There was a centre-specific medication policy, which had been reviewed in January 2015, that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines. The policy outlined that support would be offered to residents who wished to manage their own medicines and outlined the risk assessment to be used.

Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. Residents' medication was stored and secured in a locked cupboard in each premises and there was a robust key holding procedure. Staff confirmed that medicines requiring refrigeration or additional controls were not in

use at the time of inspection. Compliance aids were used by staff to administer medications to residents. Compliance aids were clearly labelled to allow staff to identify individual medicines.

A sample of medication prescription and administration records was reviewed by an inspector. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. It was noted that a medicine, prescribed to be administered on alternate nights, had been administered on two consecutive nights shortly before the inspection. This was brought to the attention of the person in charge who completed an investigation prior to the end of the inspection.

The management of short term and non-prescription medicines required review. For short term medicines, a record of the prescription was not available to the person administering these medicines to ensure that the medicine was administered as prescribed. For non-prescription medicines, there was no record maintained of consultation with a healthcare professional to ensure that the medicine is safe to be administered, the recommended dose and does not interfere with the resident's current medicines.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

Staff with whom an inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records. Stock levels were checked and reconciled on a weekly basis to identify any errors or discrepancies. A system was in place for reviewing and monitoring safe medicines management practices. The results of a medication management audit were made available to an inspector. The audit identified pertinent deficiencies and the inspector confirmed that actions had been completed.

When residents left the centre for holidays or days out, a documented record was maintained of the quantity and medicines given to the resident and/or their representative. This record was signed by staff and the resident and/or their representative. A similar record was maintained when the resident returned to the centre and the quantities were reconciled by staff.

A sample of medication incident forms was reviewed and errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. Learning from incidents was clearly documented and preventative actions were seen to be implemented. Medication incidents and the use of 'as required' medicines were reviewed on a quarterly basis to identify any trends.

Training had been provided to staff on medication management and the administration of buccal midazolam.

**Judgment:**  
Non Compliant - Moderate

**Outcome 13: Statement of Purpose**

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

**Theme:**  
Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

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

The statement of purpose contained all of the information required by Schedule 1 of the Regulations and the Statement of Purpose was clearly implemented in practice. The statement of purpose had been last reviewed in October 2015.

**Judgment:**  
Compliant

**Outcome 14: Governance and Management**

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

**Theme:**  
Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

There was evidence of a defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. There were established regular management meeting between the regional managers, the provider, the person in charge and the regional manager.

The person in charge provided effective governance, operational management and administration of this centre. The person in charge had worked with the organisation since 2002 and as a co-ordinator since 2012. The person in charge was employed full time by the organisation. The person in charge had completed a diploma in community development. The person in charge demonstrated an in-depth knowledge of the residents and their needs. Residents were observed to be familiar with the person in charge and were comfortable in his presence.

The provider nominee had arranged for an unannounced visit to the centre in the last six months to assess quality and safety. Inspectors read the report of the most recent unannounced inspection. There was evidence that pertinent deficiencies were identified, acted upon and improvements made.

The annual review of the quality and safety of care in the centre was made available to inspectors who saw that it was comprehensive and was based on the Standards and Regulations. Areas for improvement were identified and actions completed in a timely fashion.

**Judgment:**

Compliant

**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 adequate arrangements in place for the management of the centre when the person in charge is absent. A social care worker was identified to deputise for the person in charge in his absence. Inspectors spoke with the social care worker who demonstrated that she had a good understanding of her responsibilities when deputising for the person in charge. Therefore, suitable arrangements were in place for the management of the designated centre in the absence of the person in charge. The provider was aware of the requirement to notify the Chief Inspector of the proposed

absence of the person in charge from the designated centre in line with the Regulations.
<b>Judgment:</b> Compliant

<b>Outcome 16: Use of Resources</b> <i>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</i>
<b>Theme:</b> Use of Resources
<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
<b>Findings:</b> Inspectors found that the centre was adequately resourced to ensure the effective safe and effective delivery of care and support in accordance with the Statement of Purpose. Sufficient resources were available to provide support in achieving the planned goals and aspirations. There was sufficient transparency in planning and deployment of resources in the centre. The facilities and services available in the designated centre reflected the Statement of Purpose.
<b>Judgment:</b> Compliant

<b>Outcome 17: Workforce</b> <i>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.</i>
<b>Theme:</b> Responsive Workforce
<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
<b>Findings:</b> There was a planned and actual staff roster in place which showed the staff on duty during the day and sleepover staff on duty at night. Based on observations, a review of the roster and these inspection findings, the staff numbers, qualifications and skill-mix

were appropriate to meeting the number and assessed needs of the residents. A regular team supported residents and this provided continuity of care and support.

A sample of staff files was reviewed and found to contain all the required elements. There was evidence of effective recruitment and induction procedures; in line with the centre-specific policy.

Staff were observed to be supervised appropriate to their role. Regular staff meetings were held every two months and items discussed included health and safety, residents' current status, medicines management, incidents, personal care plans, fire safety and centre-specific policies. A formal and meaningful appraisal system was in place and formal appraisals had been completed for all staff.

Staff with whom an inspector spoke were able to articulate clearly the management structure and reporting relationships. The minutes of management meetings were disseminated and discussed at staff meetings. Inspectors copies of both the regulations and the standards had been made available to staff and staff spoken with demonstrated adequate knowledge of these documents.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies the programme reflected the needs of residents. Further education and training completed by staff included mandatory training and training in diabetes, epilepsy, medicines management, first aid, restrictive practices and risk management. However, as outlined in outcome 7, mandatory manual handling training had not been completed by all staff.

Records confirmed that volunteers received supervision and were vetted appropriate to their role and level of involvement in the centre.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

No actions were required from the previous inspection.

**Findings:**

The records listed in Schedules 2, 3 and 4 of the Regulations were maintained in the centre. All of the key policies as listed in Schedule 5 of the Regulations were in place and reflected the centre's practice. These policies were made available to staff who demonstrated a clear understanding of these policies. However, the policy in relation to the provision of intimate care had not been reviewed since July 2012.

Records were kept securely, were easily accessible and were kept for the required period of time. Inspectors found that the system in place for maintaining files and records was very well organised. However, correction fluid was observed to have been used in a resident's personal care plan.

An inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

Records as required under Schedule 3 of the Regulations were maintained. The residents' directory was up-to-date.

Records listed in Schedule 4 to be kept in a designated centre were all made available to inspectors.

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

**Judgment:**

Substantially Compliant

**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:***

Louisa Power  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority



## Health Information and Quality Authority Regulation Directorate

### Action Plan



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

<b>Centre name:</b>	A designated centre for people with disabilities operated by Brothers of Charity Services Ireland
<b>Centre ID:</b>	OSV-0004877
<b>Date of Inspection:</b>	22 October 2015
<b>Date of response:</b>	27 November 2015

#### Requirements

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

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

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

**Theme:** Individualised Supports and Care

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

In some circumstances, parents provided consent for residents in relation to the provision of intimate care and administration of medicines.

**1. 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,

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

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:**

1. Individual residents will be asked their wishes and afforded the opportunity to participate in and consent, with supports where necessary and to decisions about their care and support, in particular – intimate care and the administration of medication, not just in planning but in day to day situations.
2. We will review both the Medication Management and the Intimate Care Procedures to address the issue of consent and bring them into line with current regulations and legislation.

**Proposed Timescale:** 30/01/2016

**Theme:** Individualised Supports and Care

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

Where sanitary facilities were shared, intimate care plans did not take into account the measures to promote the privacy and dignity of residents during personal care in this context.

**2. 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:**

Intimate Care Plans will be reviewed to take into account the measures to promote privacy and dignity of the individuals at times when personal care is needed and in the sharing of sanitary facilities.

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

**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:**

The names of those responsible for pursuing objectives were not always clearly outlined.

**3. Action Required:**

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the

personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Personal Centred Plans will be reviewed outlining clearly those responsible for pursuing objectives.

**Proposed Timescale:** 28/02/2016

**Theme:** Effective Services

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

Some goals were not specific, focussed on activities of daily living and did not maximise the resident's personal development.

**4. Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

Personal Centred Plans will be reviewed to ensure the goals specified will maximise the residents' personal development.

**Proposed Timescale:** 28/02/2016

**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:**

A risk assessment had not been completed for open flame candles.

**5. 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:**

A Risk Assessment to be completed for open flame candles.

**Proposed Timescale:** 26/11/2015

**Theme:** Effective Services

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

Gaps were noted in documentation relating to fire checks which provide an assurance to the provider that fire precautions are regularly reviewed.

**6. Action Required:**

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

All staff will be informed to complete documentation even when house is closed e.g. at holidays and weekends. That all fire records from now on will indicate when a particular location within the Designated Centre Cluster is closed e.g. holidays, thereby not leaving any gap in the records.

**Proposed Timescale:** 24/11/2015

**Theme:** Effective Services

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

Personal evacuation plans were not reviewed when difficulties were encountered during fire drills in conjunction with suitably qualified persons

**7. Action Required:**

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

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

1. The Personal Evacuation Plan has been reviewed with input from a suitably qualified fire officer.
2. An Action Plan will be developed to implement recommendations of plan.

**Proposed Timescale:** 31/12/2015

**Theme:** Effective Services

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

A fire drill had not been completed to simulate a night-time situation where only 1 staff member would be on sleepover duty.

**8. 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:**

A fire drill will be completed to simulate night time fire drill with one staff present.

**Proposed Timescale:** 26/11/2015

#### **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Multi-disciplinary input had not been sought when planning for environmental restrictions.

**9. 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:**

MDT input has been sought with respect to environmental restrictions

**Proposed Timescale:** 27/11/2015

#### **Outcome 09: Notification of Incidents**

**Theme:** Safe Services

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

A notification relating to Regulation 31(1)(f) had not been submitted to the Chief Inspector within three working days.

**10. Action Required:**

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

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

A notifiable event and documentation has been sent to the chief inspector in HIQA retrospectively.

**Proposed Timescale:** 27/10/2015

## Outcome 10. General Welfare and Development

**Theme:** Health and Development

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

The information included in some of the discovery documents reviewed lacked detail and was not sufficient to perform a robust assessment to ensure that appropriate opportunities are made available in relation to education, training and development.

**11. Action Required:**

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

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

Review discovery document to ensure:

- a) The individual discovery documents will be reviewed to include more detail on educational and development opportunities.
- b) Individual Planning Procedure will be reviewed to ensure that the Discovery Document includes more detail on Training and Employment.

**Proposed Timescale:** 28/02/2016

## Outcome 11. Healthcare Needs

**Theme:** Health and Development

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

The information contained in a resident's communication passport did not reflect the management plan as regards the timing of administration of buccal midazolam as prescribed.

**12. Action Required:**

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

The information contained in the resident's communication passport has been updated to reflect the medication management plan with regard to emergency medication.

**Proposed Timescale:** 19/11/2015

**Theme:** Health and Development

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

Residents' wishes in relation to care at times of illness or end of life had not been ascertained for all residents. Therefore, information would not be available to guide staff in meeting residents' needs whilst respecting their dignity, autonomy, rights and wishes.

**13. Action Required:**

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

Person Centred Plans will be reviewed to include residents wishes in times of illness and end of life care.

**Proposed Timescale:** 28/02/2016

**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:**

A medicine, prescribed to be administered on alternate nights, had been administered on two consecutive nights shortly before the inspection.

A record of the prescription was not available to the person administering short term medicines to ensure that the medicine was administered as prescribed.

A record was not maintained of consultation with a healthcare professional to ensure that non-prescription medicines are administered at a safe dose.

**14. Action Required:**

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

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

a) Mis Administration of medication form completed and investigated. All staff briefed of outcome and recommended to follow procedure in administering medication and recording same.

b) The Medication Procedure is under review and will include guidance and direction to staff with regard to short term prescriptions and over the counter medication.

**Proposed Timescale:** 11/12/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Mandatory manual handling training had not been completed by all staff.

**15. 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:**

Staff training in manual handling planned for 26 November 2015

**Proposed Timescale:** 26/11/2015

**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 policy in relation to the provision of intimate care had not been reviewed since July 2012.

**16. 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:**

Intimate Care Policy is currently under review. Proposed date of completion 28 February 2016.

**Proposed Timescale:** 28/02/2016

**Theme:** Use of Information

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

Correction fluid was observed to have been used in a resident's personal care plan.



**17. 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:**

All staff advised that the use of correction fluid is not permitted on any document. Where there is a need to make a correction- strike through and initial and date.

**Proposed Timescale: 24/11/2015**