

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | Killeen Lodge |
| Centre ID: | OSV-0003380 |
| Centre county: | Kildare |
| Type of centre: | Health Act 2004 Section 39 Assistance |
| Registered provider: | Nua Healthcare Services Unlimited Company |
| Provider Nominee: | Shane Kenny |
| Lead inspector: | Anna Doyle |
| Support inspector(s): | Conan O'Hara |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 6 |
| Number of vacancies on the date of inspection: | 0 |

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 29 August 2017 09:00 To: 29 August 2017 21:00

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

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

Summary of findings from this inspection

Background to the inspection.

This was the third inspection of the designated centre. The last inspection was completed in March 2015. This inspection was unannounced, the purpose of which was to monitor compliance with the regulations and to follow up on notifications submitted to HIQA.

Since the last inspection the provider had submitted an application to vary the registration of the centre to increase the occupancy levels of the centre from five to six residents. Based on the information submitted to HIQA as part of this application; changes had been made to the staffing arrangements and the layout of the centre in order to facilitate this. The centre is now registered for six residents.

Description of the Service.

This centre is operated by Nua Healthcare and is situated in Co. Kildare. It is a seven bedroom community dwelling and currently provides care to male residents who require supports in line with their assessed needs. Direct care is delivered by health care assistants and social care workers. Nursing input is available as required.

How we gathered evidence.

Over the course of this inspection, inspectors met all of the residents living in the

centre. Inspectors engaged with residents throughout the inspection in order to ascertain their views on the quality of services provided in the centre. Two staff were met and other documents including personal plans, risk management records and safeguarding plans were reviewed.

The person in charge of the centre had left in March 2017. The provider had appointed a deputy team leader to have oversight of the centre in the interim and had submitted a notification to HIQA for this person as a person participating in the management (PPIM) of the centre.

This deputy team leader and a team leader were present throughout the inspection. They were both found to be very knowledgeable of the residents needs in the centre and had a good knowledge of the regulations. Both of these staff along with another deputy team leader had been assigned overall responsibility for the day to day governance of the centre.

Overall judgment of our findings.

Overall inspectors found that staff treated residents with dignity and responded to residents needs in a timely manner over the course of the inspection. Inspectors observed a good rapport between staff and residents and it was evident that the staff knew the residents well.

Residents looked well cared for and all of them spoken with were happy with the services being provided. Some residents spoke about concerns they had about the centre and inspectors found that these were being followed up through the complaints process.

However, major non compliances were found in two of the outcomes inspected which included Outcome 5 social care needs and Outcome 8 safeguarding.

The inspectors found that while the provider was meeting some of the requirements of the regulations under social care needs, improvements were required in the assessment of personal plans and considerable improvements were required in the discharge of residents from the centre in order to comply with the regulations.

Appropriate actions had been taken in response to safeguarding concerns in the centre which were attributed to the impact of behaviours of concern on other residents in the centre. However, safeguarding plans were not being reviewed to assess their effectiveness and ensure that these incidents were reducing in the centre. The systems in place to review the restrictive practices in the centre were not robust and the rationale for their use was not clear.

Moderate non compliances were found in three of the outcomes inspected which included Outcome 7; health and safety and risk management, Outcome 11; healthcare and Outcome 14; governance and management.

One outcome was found to be in substantial compliance with the regulations under Outcome 18; documentation and two outcomes were found to be compliant in relation to medication management and workforce.

The action plan at the end of this report outlines the improvements required.

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

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Inspectors found that each resident had a personal plan in place that contained an assessment of need which had been updated within the last year. However, improvements were required in the review of these plans and significant improvements were required in relation to the procedures for the discharge of residents from the centre.

Residents' had opportunities to participate in meaningful activities that were appropriate to their interests and preferences. For example, all residents had access to day services and spoke about accessing local community facilities which included swimming, the gym, the pub and local shops. Some residents had been on holidays this year.

A daily activities planner was completed each day outlining the planned activities for the day and the staff members who were responsible for supporting each resident.

Goals had been set for residents for the year which included long and short term goals. Inspectors found that some of these goals had already been achieved. However, some of them had not been implemented and there were no records to demonstrate how these goals would be achieved and who would be responsible for them.

Residents had opportunities to learn new skills. For example, some residents were being supported to use their bank card independently. Task analysis sheets had been developed to guide the implementation of this. However, some of the records were not consistently recorded and there was no review in place to assess, how the resident was progressing with this skill.

There were interventions documented to guide how residents should be supported with their assessed needs. These included risk assessments, standard operating procedures and a personal plan. However, some of the records contained conflicting information and on residents support needs as information was duplicated throughout the personal plans and did not always contain the correct support needs

In addition, other interventions that had been recommended by an allied health professional had not been reviewed in a timely manner in order to assess the effectiveness of the intervention. For example an intervention for one resident, required staff to complete scatter plot charts, these charts were submitted on a weekly basis to the allied health professional. However, there were no records to demonstrate that this intervention was being reviewed.

Inspectors also found that the arrangements in place to meet one residents assessed needs had not been done in a timely manner. For example, since 2015 a resident had been refusing some recommended interventions. This decision was recognised as having a negative impact on the resident. However, this was only currently being explored for the resident.

An annual review had been completed for some residents and a social report had been completed by the residents' key worker. However, the records did not clearly assess the effectiveness of supports to demonstrate how outcomes were improving for residents.

Some aspects of residents' plans' were available in an accessible format. Examples included social stories; each resident had a folder in their room containing information about their care. Visual timetables were also in place for residents to view.

One resident had transitioned to the centre since the last inspection. They met with inspectors and informed them that they were happy with this move.

However, inspectors found that the discharge of residents from the centre was not being conducted in line with the regulations as there were no records to demonstrate that a proposed discharge was in line with assessed needs or whether it had been planned for and agreed with the resident or their representative where appropriate. This was discussed at the feedback meeting and the details of this are not contained in this report in order to protect the resident's anonymity.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Inspectors found that while there were policies and procedures in place for risk management and emergency planning in the centre, improvements were required to some risk management practices.

Inspectors found that there were systems in place for the assessment, management and review of incidents that occurred in the centre. All incidents were recorded on an incident/accident form. The information contained in the forms was then discussed at a clinic review meeting attended by senior managers and allied health professionals. Incidents that occurred in the centre were also discussed at staff meetings.

Records of all incidents were collated each month in the centre. However, this information was not reviewed so as to identify trends and inform future learning.

Residents had individual risk assessments in place and corresponding standard operating procedures in some instances that guided risk practices. However, improvements were required so as to ensure that control measures were in place for all identified risks and to ensure that existing control measures identified could be fully implemented. For example, control measures outlined for one resident were conflicting with another recommended intervention in place for them.

Another risk assessment in place for transport did not outline the actual control measures in place to prevent the reoccurrence of a known risk to a resident while using service vehicles.

There were effective fire management systems in place that included:

- arrangements in place in the event of a full evacuation of the centre
- appropriate fire fighting equipment and means of escape
- records demonstrating that fire equipment was serviced appropriately
- records demonstrating that fire drills were being completed
- residents had personal emergency evacuation plans in place.

Inspectors found that improvements were required regarding the template for fire drills and acknowledge that this is being addressed by the provider as a wider service improvement initiative.

Infection control standard precaution measures were in place, which included access to personal protective equipment, hand sanitising gels and colour coded cleaning standards were implemented.

The vehicles used for the transportation of residents were insured and their road worthiness had been checked and displayed in the vehicles. Inspectors also saw records to demonstrate that residents could raise concerns about transport and a new larger vehicle had recently been purchased in response to complaints lodged by residents.

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:

There were policies in place to protect residents being harmed or suffering abuse. However, significant improvements were required in the use of restrictive procedures in the centre and some improvements were required to ensure that safeguarding plans were reviewed and interventions in response to behaviours of concern were being fully implemented.

Inspectors found that the reasons for using restrictive procedures were not clearly outlined in residents' personal plans. In particular, the use of a chemical restraint in response to behaviours of concern had not been considered as a restrictive practice and therefore had not been reviewed as such.

Other restrictions in place, had not been appropriately reviewed so as to ensure that the least restrictive practice was in place. The rationale for its use was not clearly documented and there was no evidence that residents or their representatives had consented to this. Some consideration had been given to the impact of some restrictions for other residents in the centre around providing alternative access to some restricted items.

Inspectors found that incidents of abuse had been recorded, were investigated and the relevant authorities were informed in such an event including HIQA. Safeguarding plans had been developed in response to these concerns which all related to the impact of some behaviours of concern on residents in the centre. However, inspectors found that these plans were not being reviewed to ensure their effectiveness.

Residents had reactive strategies to behaviours of concern recorded in their personal plans. Associated risk assessments and standard operating procedures were also in place to guide staff practice in supporting residents.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspectors found that residents had access to allied healthcare services which reflect their different care needs. However, improvements were required in end of life plans and the review of healthcare interventions for residents.

From the sample of personal plans viewed, each resident had an assessment of need completed on their healthcare needs. Supports were in place to meet those needs and residents had access to a wide range of allied health professionals in line with their assessed needs which included psychology, speech and language, counselling services and occupational therapy.

Staff met were very knowledgeable around the residents' healthcare needs and there was a system in place to ensure that all healthcare need reviews and referrals were being followed up for residents in a timely manner.

Interventions recommended by allied health professionals were being implemented. However, while there was a system in place for staff to submit some of these interventions to the allied health professionals it was not clear how this was being reviewed so as to assess the effectiveness of the intervention.

For example one resident's fluid intake was recorded daily, the records of which were submitted to the prescribing allied health professional, however, there was no review of this in place. Another resident's food intake was recorded daily and this had not been reviewed to assess the effectiveness of this intervention for the resident.

An end of life care plan was in place for one resident. Inspectors found that while the information recorded on this form was well intentioned in that it was recording the wishes of the resident. The methodology used was not in line with best practice and required review. The details of this were discussed at feedback and are not contained in this report in order to protect anonymity.

Residents had access to wholesome and nutritious meals in line with their personal

preferences. Choices were available for residents and menu plans were discussed at resident forum meetings. Residents were supported to prepare some meals in the centre.

While it was noted in one resident's plan that they had been recently assessed by speech and language therapist in relation to a swallow assessment and no concerns had been noted, this report was not available in the centre on the day of the inspection. The report was submitted post inspection and on review inspectors found that recommendations had been made from this review that was not included in the residents plan on the day of the inspection.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Improvements were required in this policy to ensure that staff were guided on the protocols to follow where a resident refused medications.

The inspectors found that the designated centre had appropriate procedures in place for the ordering, receipt, prescribing, storage disposal and administration of medications in the centre.

Medications were supplied in blister packs and there were auditing practices in place to ensure that the medication contained in the blister packs were correct.

As required medication stored in the centre were audited on a weekly basis by the team leader. This medication was not dispensed in blister packs and inspectors found that appropriate labels, expiry dates and the name for who the medication was prescribed were in place on the medication containers.

In addition, the inspectors found that there were guidance documents in place for the administration of medication in the form of "standard operating procedures". Any staff met were very clear on when it was appropriate to administer this medication and the maximum doses were outlined on the prescription sheets for each resident.

Staff were clear about why medication was prescribed for residents and all staff were trained in the safe administration of medication.

Medication prescription sheets had been recently reviewed by a doctor and while the information contained on the prescription sheet did not always tally with the names of medication prescribed on the blister packs, staff were aware of the need to confirm the generic/trade name of this medication prior to administering the medication.

Medication prescribed was stored securely. A fridge was available in the centre for the storage of medication as required. Records were appropriately maintained to ensure that the temperature was monitored daily. Discontinued medication or medication no longer in use was stored separately and recorded prior to being returned to the pharmacy.

Inspectors were informed that there were no controlled medications stored in the centre and that there had been no medication errors in the centre since the beginning of the year. However, provisions were in place in such an event which included, contacting the senior manager on call for advice, completing a medication error form and there was a rolling agenda item on the minutes of staffing meetings to discuss errors in such an event to inform learning.

A medication audit had also been completed in the centre.

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:

Inspectors found that the provider was not fully meeting the requirements of the regulation as it was unclear who was appointed to fulfil the obligation of the person in charge on the day of inspection.

The person in charge of the centre had left in March 2017. The provider had appointed

a deputy team leader to have oversight of the centre in the interim and had submitted a notification to HIQA for this person as a person participating in the management (PPIM) of the centre.

This person was met at the inspection and was found to be knowledgeable of the residents' needs and the regulations. However, inspectors were informed that in addition to this a team leader and another deputy team leader were also in place to oversee the centre. All of whom reported to a regional manager and while staff were clear that they would report concerns to any of the above mentioned staff, the lines of accountability were not clear as the PPIM nominated as fulfilling the responsibilities of the person in charge was reporting to a team leader in the centre.

Inspectors acknowledge that the team leader appointed to the centre and present on the day of the inspection was very knowledgeable of the residents needs and the requirements outlined in the regulations. They were supernumerary in their role and for the most part had been ensuring effective supervision of the care being provided in the centre.

From the records viewed regular staff meetings were held in the centre. All staff met stated that they felt supported and had supervision completed on a monthly basis with the team leader or deputy team leaders. These records were not reviewed as part of this inspection.

An unannounced quality and safety review had been completed for the centre in May 2017 and an action plan had been developed in response to issues raised.

An annual review had been completed for 2016, however this did not include the views of residents or their representatives. Inspectors acknowledge that this was demonstrated in the last unannounced quality review of the centre and going forward this information would be included in the annual review for the centre.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

No actions were required from the previous inspection.

Findings:

The staffing levels in the centre during the day were appropriate in order to meet the assessed needs of residents.

On reviewing a sample of safeguarding plans and risk assessments in the centre, inspectors found that controls measures included high supervision or one to one support for residents to mitigate risks and ensure residents were safeguarded. However, it was not clear how this could be implemented given that staffing was reduced to two staff in the evening times. Inspectors acknowledged that no trends were identified at these times. This issue is actioned under outcome 8.

There was a planned and actual rota in place in the centre. A team leader or deputy team leader was in place every day in the centre and in their absence staff had access to over the phone advise or, to report concerns to senior personnel.

The inspectors reviewed a sample of training records and found that staff had up-to-date training in fire safety, safeguarding and medication management and manual handling. In addition, staff had received training in dementia care.

There were no volunteers employed in the centre. Staff files were not reviewed as part of this inspection.

Judgment:

Compliant

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

The inspectors found that the medication policy for the centre required review to include the protocol staff should follow in instances where a resident refuses medication.

No other aspects of this outcome were inspected.

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:

Anna Doyle
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 report¹

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|----------------------------|--|
| Centre name: | A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company |
| Centre ID: | OSV-0003380 |
| Date of Inspection: | 29 August 2017 |
| Date of response: | 27 October 2017 |

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

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

The review of personal plans conducted did not assess the effectiveness of the plans for residents.

Some interventions implemented were not reviewed to assess their effectiveness.

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

Task analysis sheets used to teach independent living skills were not consistently recorded and were not reviewed.

1. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

1. Personal Plans will be reviewed in their entirety by the PIC to assess the effectiveness of the plan and take into account changes in circumstances and new developments for residents. Meeting held 23.10.2017 between PIC and Director of Service regarding same.
2. The final Personal plans will be discussed with all staff at their team meetings in November and December.
3. Methods to teach independent living skills will be reviewed by the PIC to assess their effectiveness and this will include the review of task analysis.
4. Training on Task analysis will be completed with the staff team [Due: 31st December 2017].
5. Effectiveness of Resident's Personal Plans will be reviewed at the staff monthly team meetings.
6. Annual reviews are held for the residents, representatives and relevant professional bodies to review the Personal Plan and its effectiveness.

Proposed Timescale: 31/12/2017

Theme: Effective Services

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

Some goals set for residents had not been implemented and there were no records to demonstrate how these goals would be achieved and who would be responsible for them.

2. Action Required:

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

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

1. Personal Plans (including goals for residents) will be reviewed in their entirety by the PIC to ensure the information is accurate and demonstrate how goals will be achieved and identify the responsible person.
2. Training on "goal setting for residents" will be complete with staff at their team meeting on the 26th October and their team meeting in November.

Proposed Timescale: 01/12/2017

Theme: Effective Services

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

The arrangements in place to meet one residents' assessed needs had not been done in a timely manner.

Some interventions in place were duplicated and conflicting information was recorded on these records around the supports in place.

3. Action Required:

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

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

1. Personal Plans will be reviewed in their entirety to ensure they have accurate information and meet the assessed needs of the residents.
2. This will be discussed with staff at the team meeting on the 26th October and in November.

Proposed Timescale: 01/12/2017

Theme: Effective Services

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

There were no records to demonstrate whether a proposed discharge of a resident from the centre was discussed, planned for or agreed with a resident or their representative.

4. Action Required:

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

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

Following an assessment of need in line with the Centre's new Policy and Procedure on Admissions, Discharges and Transitions of Residents, the proposed discharge of a resident will be discussed, planned for and agreed with the resident and the resident's representative.

Proposed Timescale: 17/11/2017

Theme: Effective Services

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

There were no records to demonstrate whether the proposed discharge of a resident from the centre was in line with their assessed needs.

5. Action Required:

Under Regulation 25 (4) (c) you are required to: Discharge residents from the designated centre in accordance with the resident's assessed needs and the resident's personal plans.

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

1. The proposed discharge of a resident will take place in line with their assessed needs.
2. The PIC is to complete a Comprehensive Needs Assessment for the resident identified as part of the proposed discharge.
3. Following assessment of need, the resident's discharge plan will be updated.
4. All discharges from the Centre will be completed in line with the Centre's new Policy and Procedure on Admissions, Discharges and Transitions of Residents [PL ADT 001]

Proposed Timescale: 17/11/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

A control measure in place to mitigate a risk for one resident was outlined in another intervention for the resident as being restricted.

One risk assessment for transport did not outline the control measures in place to prevent the reoccurrence of a known risk to this resident.

The collation of incidents that occurred in the centre were not reviewed so as to identify trends and inform future learning.

6. 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:

1. Personal Plans will be reviewed in their entirety to ensure the information is accurate and of support to the staff team. This includes the identification of key risks for each resident, the level of risk identified, the management of the risks and the interval for review of the risks.
2. Key risks for the resident and for the staff will be compiled in a Centre Specific Risk Management Register. Person centred risks of a resident shall be included. Risks shall be risk rated and controls shall be reviewed to ensure all potential controls are in place. The Centre Specific Risk Management Register shall be reviewed on an annual basis or

more frequently if required. PIC to ensure it is fully up to date and reflective of the needs of the residents and staff.

3. The Centre Specific Risk Management Register will be communicated on a daily basis to the staff team as part of the daily handover.

4. The PIC and Deputy Team Leader will receive training on Risk Management and the development of the Centre Specific Risk Management Register

5. Resident's risks will be reviewed and compiled in an individual risk management plan in line with the Individual Risk Management Policy [PL- OPS-012].

Proposed Timescale: 01/12/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There were no records to demonstrate that residents or their representatives had consented to the use of restrictive practices in the centre.

7. Action Required:

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

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

1. Process for obtaining Informed Consent from residents for therapeutic interventions is under review. The organisation will ensure this is fully person centred and in line with HIQA regulations and standards.
2. Where therapeutic interventions are required for any resident, informed consent shall be obtained from each resident, or his or her representative, in line with the Regulations.
3. New Policy on Consent to be implemented.

Proposed Timescale: 01/12/2017

Theme: Safe Services

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

The use of a chemical restraint in response to behaviours of concern had not been considered as a restrictive practice and therefore had not been reviewed as such. In addition, it was not clear if the resident, their family member or an advocate had been consulted on the use of this restraint; and there was no comprehensive review of this restraint.

Other restrictions in place, had not been appropriately reviewed so as to ensure that

the least restrictive practice was in place. The rationale for its use was not clearly documented.

8. Action Required:

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

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

1. An MDT meeting was held on 12th of September to review the restrictive practice identified for one resident [Completed 12th September 2017].
2. The restrictive practice linked to the resident's medication is been discontinued.
3. All restrictions that are currently in place in the Centre will be reviewed by the PIC and Director of Services to ensure the least restrictive procedure is in place for the shortest duration necessary.
4. Any restrictions in the Centre will be identified in the Centre Specific Risk Register and reviewed by the PIC.

Proposed Timescale: 01/12/2017

Theme: Safe Services

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

Safeguarding plans were not being reviewed in the centre so as to ensure that the measures in place were effective.

9. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

1. Safeguarding Plans will be reviewed by the PIC to ensure that the measures in place are effective.
2. Centre specific safeguarding plan to be developed. Within this potential vulnerabilities and preventative measures to mitigate risk will be identified.
3. Centre specific safeguarding plan to be discussed at daily handover in the Centre.
4. The Centre roster was reviewed following the Inspection to ensure adequate resources were in place.
5. Resources will be regularly reviewed to ensure they meet the needs of the residents

Proposed Timescale: 01/11/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

One end of life plan in place for a resident was not in line with best practice guidelines.

10. 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:

1. The end of life plan in place for a resident will be reviewed in line with best practice while ensuring the plan respects the rights and wishes of the resident [Completed 23.10.17]
2. A meeting will to be held in relation to the residents end of life care plan. Resident will be present and representatives will be invited and involved in the process.

Proposed Timescale: 31/12/2017

Theme: Health and Development

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

A swallow assessment that had been completed for one resident was not available on the day of the inspection and recommendations from this were not included on the residents plan.

11. 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:

Resident's Personal Plan will be reviewed to ensure the recommendations in a residents swallow assessment are incorporated.

Proposed Timescale: 01/11/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

It was not clear what the lines of accountability were in the centre in the absence of a person in charge.

12. Action Required:

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

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

1. A new PIC was identified prior to inspection and has been appointed to the Centre and commenced their role on the 5th of September 2017.
2. All staff have received key task lists are in place for the PIC, Deputy Team Leaders and Social Care Workers within the Centre.

Proposed Timescale: 05/09/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

The medication policy for the centre required review to include the protocol staff should follow in the event of a resident refusing medication.

13. Action Required:

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

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

The Centre's Policy on the Safe Administration of Medication will be reviewed to include a protocol of medication refusals.

Proposed Timescale: 01/11/2017