Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Centre 1 - Aras Attracta
Centre ID:	OSV-0003321
Centre county:	Mayo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Suzanne Keenan
Lead inspector:	Ivan Cormican
Support inspector(s):	Anne Marie Byrne;Christopher Regan-Rushe
Type of inspection	Announced
Number of residents on the date of inspection:	36
Number of vacancies on the date of inspection:	1

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:
16 May 2017 09:30	16 May 2017 19:30
17 May 2017 08:30	17 May 2017 19:00
18 May 2017 08:30	18 May 2017 14:30

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

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

Summary of findings from this inspection

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

Over the last three years, this centre has been subject to an increased regulatory monitoring programme, due to significant concerns relating to the safety and wellbeing of residents who lived in the centre. In response to these concerns an increased regulatory monitoring programme was developed by the Authority for each

of the three centres located on the Aras Attracta campus.

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

During this inspection, inspectors also reviewed the actions the provider had said they would take following the centre's previous inspection, conducted on 12 and 13 of October 2016. The designated centre is part of the service provided by the Health Service Executive in Mayo. The centre provided a full-time seven day residential services to adults with a intellectual disability.

How we gathered our evidence:
During the inspection, inspectors spent time observing all of the residents and met with three residents and one family member. Inspectors also spoke with 13 staff members, including the person in charge. Inspectors met 2 other staff members who worked across the campus. Inspectors spent time observing interactions between residents and staff and reviewed documentation such as personal plans, risk assessments, fire precautions, medication records, emergency planning procedures, policies and staff files.

Description of the service:
The designated centre comprised of two units that accommodated up to 37 residents who have intellectual disabilities, psychiatric and medical conditions. The units were located on a large campus based setting on the outskirts of a rural town. While some residents had their own bedrooms, many residents shared bedrooms, with up to three other residents. Each unit had an adequate amount of shared bathrooms and toilets, which were equipped to cater for the needs of residents. There were also adequate communal rooms available for residents, to have visitors such as family and friends.

Overall judgement of our findings:
Inspectors found that the provider's governance and management systems in the centre were inadequate and this resulted in poor outcomes for residents.

The provider had not ensured that the failings identified from the previous inspection had been addressed. The provider had set out 27 specific actions, with timeframes, that they had submitted to HIQA following the October 2016 inspection. Inspectors found that 20 of these actions had not been completed.

Of the 18 outcomes inspected, seven outcomes were found to be in major non-compliance, nine were found to be in moderate non-compliance and two outcomes were found to be in compliance with the regulations. The major non compliances wee found in key areas such as safeguarding, risk management, the rights and dignity of residents and social care.

Due to significant concerns, three immediate actions were issued to the provider in regards to the safety and quality of care provided to residents. Two immediate

actions were in relation to fire precautions and one immediate action was in relation to infection control.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that the provider had taken actions to improve consultation with residents since the previous inspection, but further improvement was required. Further improvements were also required to the management of complaints. The provider had completed some of the actions from the previous inspection, but others had not been completed and this continued to impact on the quality of residents' privacy and dignity.

During this inspection, inspectors found residents' meetings were now occurring on a monthly basis and easy-to-read minutes of these meetings were available to residents. These meetings provided residents with an opportunity to discuss areas such as complaints, suggestions for activities and to give general feedback on the service provided. Residents were frequently consulted by staff on what activities they wanted to participate in, and this consultation process was found to be well documented and included the interests, hobbies and routines each resident liked to engage in. Inspectors observed staff interacted well with residents throughout the inspection process, and staff who spoke with inspectors said that all efforts were being made by them to accommodate residents' requests and wishes. Advocacy services were also available to residents and information regarding these services was displayed in the centre.

However, the inspectors found residents were not consulted in the provider's recent decision to spend €9000 of residents' personal money to purchase assistive technology for each resident. Since the last inspection, 13 residents were provided with personal tablet computers with a cost to each resident of €433. At the time of this inspection, a further eight residents were awaiting the delivery of their personal tablet computers.

Inspectors reviewed records, spoke with staff and residents and found that the provider had failed to carry out individual assessments to identify the appropriateness of this technology to meet the needs of each resident. The provider had not consulted with residents or their representative prior to making the purchases. One resident informed inspectors that although they were aware they paid for the personal tablet computer, they had not been consulted about the purchase and did not know why they required the personal tablet computer.

While residents' privacy and dignity were respected in relation to personal communications, relationships, intimate and personal care, inspectors found the arrangements in place to promote residents' privacy and dignity in shared bedrooms remained inadequate. Since the last inspection, the centre had reduced the number of residents sharing multiple occupancy bedrooms and additional privacy screening had been installed. However, inspectors observed portable privacy screens were still in use in the centre, and these continued to provide inadequate privacy and dignity arrangements for residents in shared bedrooms. Furthermore, some privacy screening continued to be clinical in nature and did not provide a homely feel to the environment.

During a review of residents' meeting minutes, inspectors noted some aspects of residents' privacy and dignity was not respected, with information about named, individual residents being discussed in a negative manner while other residents and staff were present. In one instance, inspectors read that residents had brought maintenance issues to the attention of the provider during these meetings. However, named residents were blamed for the maintenance issues and this was an example of the dignity of residents being compromised.

Inspectors reviewed the management of residents' finances within the centre. Residents' money was securely locked away, with a record maintained of all transactions and withdrawals made. A sample of residents' account balances were spot checked by inspectors and a member of staff, and no errors were found. Residents had lockers, drawers and wardrobe space available to them in their bedrooms. Some residents were recently supported to buy their own furniture for their bedrooms and staff who spoke with inspectors informed them of plans to support all residents to do this, if they wished.

One resident who spoke with inspectors stated that, to promote their privacy, they had their own key to their bedroom. However, similar arrangements were not in place in shared bedrooms and the provider had failed to ensure residents in these rooms had access to lockable storage space which included space to safely store their valuables such as their newly purchased personal tablet computer.

The complaints procedure was prominently displayed in the centre and available in an accessible format for residents. A complaints register was maintained for the centre which detailed the nature and management of complaints received. Although the provider had systems in place to support residents to make complaints, inspectors found gaps in the management of some complaints raised by residents at monthly meetings. For example, inspectors found that a number of complaints were made by residents at different meetings held since January 2017. However, these complaints were not responded to during or after the meetings. These complaints were brought to the attention of the person in charge during the inspection, who was unable to provide

records to evidence the recording, acknowledgement and resolution of these complaints made by residents. In addition, inspectors found that not all complaints, which had been resolved, included evidence about whether the complainant was satisfied with the outcome.

Judgment:
Non Compliant - Major

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that the provider and person in charge had not addressed the actions arising from the previous inspection. During this inspection inspectors found that the provider had failed to support residents to develop skills in using newly purchased table computers to aid with communication..

Since the last inspection, communication passports were developed for all residents. These guided on residents' preferred communication style and informed staff on how to support residents with specific communication needs. Weekly initiatives with staff on the use of manual sign language were occurring in the centre and these were coordinated by the Speech and Language Therapist. Pictorial choice boards were also developed for residents to reference when choosing the social activities they wished to engage in. Residents' meeting minutes were found to be in easy-to-read format with pictorial references on the topics being discussed.

Staff who spoke with the inspectors had a good understanding of residents' specific communication needs. Staff told inspectors that technology aids were in place for residents to use; such as, projector screens and picture format tools. However, residents who had recently purchased a personal tablet computer told inspectors that they had not received support or guidance on to how to use them. Inspectors also found that the provider had not arranged for internet access to be provided in the centre to enable residents to fully use the personal tablet computers to access proposed online communication tools.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that the provider had addressed the actions arising from the previous inspection.

Since the last inspection, residents had increased opportunities to engage in the wider community. A number of residents were recently supported to go on holiday, with further trips planned for the coming months. The centre also had increased access to independent community transport to bring some residents to community based events.

Residents were facilitated to receive visitors as they wished, with two visiting rooms available in the centre for residents to use. Inspectors met with some family members who said they are welcomed to the centre at all times, and had not experienced any restrictions in visiting their relatives. Residents who spoke with inspectors said they enjoyed receiving visitors, and sometimes chose to meet visitors in the privacy of their own bedroom. Family members told the inspectors that they are regularly contacted by the centre regarding any changes to the wellbeing of their relative. Family members said they are continually informed where there are any changes to personal plans or where accidents and incidents occur which involved their relative.

Inspectors met with members of staff from the centre's activation team, who support residents in accessing the community. These staff members informed inspectors that since the last inspection, residents have a lot more opportunities to get out into the community, with many residents involved in various social groups.

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

Findings:
Inspectors found that the provider had not addressed the actions arising from the previous inspection. Written agreements were still found to not adequately describe the services being provided to residents for the weekly contributions they were being charged.

The written agreements were reviewed by inspectors which were found to have an appendix attached outlining the additional charges that residents would need to pay. The written agreements also stated that each resident's weekly contribution would be determined following a financial assessment, which would inform what category of charges the resident was assessed for. Inspectors found that the charge identified from this assessment was not detailed in residents' written agreements, and did not inform residents how their weekly contribution had been calculated.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors found that the provider had addressed all three actions arising from the previous inspection within the agreed timeframes. However, during this inspection it was identified that improvements were required to the availability of personal plans to residents, the arrangements in place to meet residents' assessed needs, the assessment of residents with therapeutic needs and transitional planning for residents.

Improvement had been made by the provider to the assessment of residents' personal

needs. This ensured that residents had up-to-date assessments in place. These were being regularly updated to reflect the level of care and support each resident required. However, inspectors found an overall deterioration in the arrangements in place to implement the actions based on the identified social care needs of residents. This has impacted on residents' abilities to exercise choice over how they wished to spend their day, with fewer and less reliable opportunities for residents who were wheelchair users to engage in social activities external to the centre.

Inspectors found that since the last inspection, opportunities for residents to engage in social activities of their choice supported by an activation team had improved. However, the residents' ability to complete these social opportunities was determined by the availability of staff to support residents and the availability suitable transport for wheelchair users. Inspectors found that members of the activation team were being used to cover care assistant staff absenteeism and social outings had been cancelled as a result. For instance, during a 14 day period, inspectors identified 10 days where members of the activation team were required to cover care assistant staff absenteeism. Staff informed inspectors that when this occurs, residents' planned community based activities are cancelled as there is no contingency plan in place to ensure residents were still able to attend these activities as planned.

Since the last inspection, additional transport was available at the centre and non-HSE staff were also now insured to drive this. Inspectors found that some residents, who were wheelchair users, had made a number of requests at residents' meetings for increased trips outside of the centre. However, staff told the inspectors that they were unable to provide these residents with the same opportunities as their peers to access the community, and to engage in those activities which had been personally requested by these residents. Inspectors were told that there were approximately 17 residents who used a wheelchair. Inspectors found that the vehicles could only provide transport for one wheelchair user at a time and while some residents who used a wheelchair were able to transfer into a vehicle seat, others could not. This meant that some residents had to wait their turn before they could complete a community based activity.

Inspectors found that residents spent much of their day with minimal input and interaction from staff. Inspectors spent extended periods observing the daily routine for residents. For example, on one of the mornings, an inspector observed six residents who were in the communal lounge and some of them had been assessed as requiring one-to-one support. This area was screened off from the main corridor of the wing. During this time inspectors noted that residents did not have one to one support, there was no active engagement or activities being undertaken with residents and the two support staff who were assigned to working with this group were attending to needs of another resident in their bedroom.

In the second wing, the inspector found that some residents had been assessed as requiring one-to-one staff support at all times. However, this level of staff support was not being provided to these residents. In one instance, inspectors observed one of these residents who had been left unsupervised in a communal area of the centre. During this time, inspectors saw the resident begin to engage in an unsafe activity which required the inspector to immediately alert a member of staff in order to ensure the residents safety.

In the final wing, inspectors observed residents, who used wheelchairs, who had been assembled facing the television, which was tuned to the radio. Many of these residents were asleep. An inspector noted that some of these residents had high neck wear or bulky neck attire such as scarves or necklaces and that these residents were leaning forwards while sleeping with their necks on their chins. There was one member of staff in the unit at the time, facing away from the residents for the duration while preparing medication. Because it appeared that the neck attire was constricting some residents, an inspector alerted the nurse to the risk of the restrictive neckwear while residents were sleeping in that manner. During this time inspectors noted no active engagement or activities being completed with residents.

Residents' files were reviewed by inspectors and were found to include an assessment of residents' needs. However, some of these plans had not been reviewed on a minimum annual basis. Inspectors noted some gaps in the completeness of the social care assessments and the provision of support to meet the needs of some residents with dementia. For example, some residents with dementia had been identified by the activation team as requiring therapeutic activity programmes. Inspectors noted that schedules were in place to demonstrate what activities these residents were engaged in. However, these had not been reviewed following a recent assessment of the residents' current therapeutic needs which had changed following deterioration in their cognitive ability. In addition, these plans were found to have not been reviewed on at least an annual basis, as required by the regulations.

For other residents, personal plans had been developed for each resident which guided the care and support required by residents each day. These provided clear guidance on each resident's goals, the actions required to achieve them, the named person responsible for supporting the resident to achieve these and the timeframes for completion. The plans were being updated with the progress made by each resident towards achieving their goals.

Records of personal plan reviews were available and demonstrated the involvement of residents' key workers, care staff, allied health professionals, the resident and their representatives in these reviews. Family members who spoke with inspectors told of how staff also facilitated telephone reviews to be held with family members who were not able to attend review meetings. These plans were reviewed on a minimum annual basis and residents. Although inspectors found that personal plans were available to residents if they wished to review them, they were not available in an accessible format.

Some residents had been identified for transition to the community in 2018. A transition team was assisting the provider in the assessment and sourcing of suitable accommodation for residents to transition to. Inspectors were told by members of the transition team that housing profiles had been completed for each resident identified for transition. These detailed the residents' preferred choice of address, bedroom preference and the number of people they wished to live with. Inspectors were provided with an overview of the transition plan for the centre which identified where residents were potentially moving to, who they would be living with and the planned timescale in which the move would occur. Inspectors found that some staff members had received training in supported self-directed living and were supporting the development of

meaningful activities for residents, who were preparing to transition from the centre. However, inspectors found that the provider had not provided information on the services and supports required by these residents to help them prepare for transition.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The provider had one action from the previous inspection which had been partially addressed. On this inspection, inspectors found that some improvements had been made to the comfort of the centre as some residents had been supported to purchase there own furniture and soft furnishings for their bedrooms. However; inspectors found that the premises did not meet the requirements of the regulations and that communal areas continued to require improvements in relation to decoration and furnishing.

The designated centre comprised of two units within a large premises of a congregated setting. Both units were in close proximity to each other and shared a common entrance. The units were home to 37 residents, including one respite bed. One unit had communal areas, a separate installed kitchen, which residents could access, and a number of single and shared bedrooms. The second unit was divided into three wings with a central kitchen area. However, residents did not have access to these kitchen facilities. Each wing had a large communal area and a separate visitors room was available in the unit. Again, in this unit there were a number of single and shared bedrooms.

Inspectors found that communal areas were not homely in nature, with one area having seating and tables located within walkways and corridors. Ceiling panels in various areas of the centre also required attention as significant water damage was visible. Some residents had purchased personal furniture for their bedrooms and pictures of family and friends were also on display. Inspectors found that this had promoted the resident's individual choice and helped to create a more homely environment. However, inspectors also found that not all bedrooms were individualised in this manner. Inspectors also noted that one resident's bedroom had an en-suite toilet which had a shower curtain in

place of a door and some residents in this centre continued to share bedrooms with one or more resident, which impacted on their privacy.

Overall, inspectors found that the premises did not promote a homely environment for residents and did not meet the requirements of Schedule 6 of the regulations in regards to providing adequate private and communal accommodation.

Inspectors noted that while the centre was well equipped with suitable aids and appliances such as hoists and high-low beds, including pressure relieving mattresses, not all hoists had been serviced as required and there were a number of broken wheelchairs being stored in the centre.

The centre had adequate laundry facilities and staff stated that residents would be assisted to launder their own clothes if they so wished. The centre also had suitable arrangements for the disposal of domestic and clinical waste.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors found that the provider had again failed to implement sufficient risk management arrangements. The provider's action plan following the previous inspection contained five specific actions relating to risk management, and inspectors found that the provider failed to effectively implement four of these actions.

On this inspection, the provider was also required to take three immediate actions relating to issues that presented an immediate risk to residents:
1- Inspectors found that one emergency exit was blocked by equipment which rendered the exit unusable in the event of a fire. The provider removed the equipment on the day of inspection.
2- The provider had introduced a campus based pager system to support the evacuation of Centre 1 in the event of an emergency. The inspector reviewed this system on the day of inspection and found that the provider had not ensured that staff had an appropriate understanding of this system and of their required response in the event of an emergency. This rendered this system of responding to emergencies ineffective. The inspector visited another centre on the campus in which staff were required to respond

using this system. The staff were not in possession of the pager when the inspector met them and one staff member was unsure as to it's purpose. Staff reported that they were off site earlier in the morning and therefore the pager system would not have worked if there had been an emergency. Staff members also stated that they would not always be able to respond to the pager system due to the care requirements of residents in their own centre. In response, the provider made arrangements on the day to ensure that all staff were aware of these procedures. Subsequent to the inspection, the provider also submitted an action plan to address these issues on an on-going basis.
3- Inspectors found that a room which was to be used for therapeutic purpose by some residents was very dirty, with mould growing in parts of it and it required cleaning and posed an infection control issue for residents. The provider ensured that the room was cleaned on the first day of inspection and in the days following submitted an action plan to address this issue.

On this inspection, other improvements were also required in regards to infection control. Inspectors were not informed to the presence of Methicillin resistant Staphylococcus aureus (MRSA) and the centre had no signage in place in regards to infection control procedures. Care staff on duty were aware of the presence of MRSA and stated that they would use universal precautions as a control measure. However, ancillary staff interview stated they were unaware of the presence of MRSA. Ancillary staff also stated that they would use the same equipment to clean all areas of the centre including rooms where MRSA was present. Risk assessments in place for the presence of MRSA also failed to have appropriate controls in place to reduce potential cross infection and were not signed or risk rated.

The centre had an up-to-date health and safety statement and vehicles used by residents had suitable road tax and insurance. Staff also had a good knowledge of the reporting system used for adverse events. The person in charge had responded to documented adverse events in a timely manner.

In relation to fire precautions, inspectors also found that the provider had failed again to effectively respond to issues. In addition to the ineffective pager system for responding to emergencies, the provider had failed to implement the recommendations of their own fire consultant, such as the installation of fire doors and additional emergency lighting. However, the provider had secured funding to implement these actions and a schedule of works had been agreed with an external contractor.

The provider had some fire precautions in place. Staff were conducting regular checks of fire equipment and emergency exits, but had failed to identify that one exit was blocked with assistive equipment. Fire equipment was serviced as required, fire drills were conducted on a regular basis, smoke detection equipment was in place throughout and all staff had received fire training.

The provider had not responded adequately to issues which were identified during fire drills. Two recent fire drills highlighted that not all residents could be evacuated from the centre due to a lack of working wheel chairs. This was brought to the attention of the person in charge who ensured that appropriate serviced equipment was in place to support the evacuation of all residents. In another fire drill report, it was noted that seven staff attended to assist with evacuation, but a recent fire risk assessment stated

that a minimum of 10 staff were required to support the evacuation of residents. This issue had not been responded to following the fire drill.

Staff in general had a good knowledge of fire procedures within the centre, however, some staff members stated that they did not know how to read the newly installed fire panel and had not received training on how to do so.

Residents were supported by personal emergency evacuation plans; however, inspectors found that these documents did not fully account for the assistance that residents may require when they may be in bed or using mobility aids.

Overall, inspectors found that the provider had ineffective systems in place for the identification, recording, monitoring, review and management of risk within the centre. Where risks were identified, the provider did not implement an effective plan to ensure that identified risks did not affect the safety and quality of care which the residents received.

Inspectors also found that the risk management policy failed to contain critical components, as required by the regulations, which impacted on the ability of staff and management of the centre to safely address identified risks in a concise and coordinated manner, for example
- the provider failed to effectively address concerns raised on recent fire drills in terms of the escalation of risk within the centre
- the provider failed to ensure that the presence of MRSA within the centre had been appropriately addressed in terms of risk
- the provider failed to ensure that fire risk assessments and procedures had been appropriately reviewed to ensure staff awareness of the fire precautions used within the centre

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
On the day of inspection, inspectors found that residents were not adequately protected from the risk of abuse. In addition, the monitoring of active safeguarding plans was insufficient. The action from the previous inspection had not been addressed with further improvements also required in the management of the use of chemical interventions. Overall inspectors found a lack of improvement in this outcome, and identified further deficits in relation to the referral and review of residents who require behavioural support, staff training and the consent for therapeutic interventions

Some residents were able to tell inspectors that they were happy and felt safe in their home. However, many residents were unable to verbalise their thoughts to inspectors. Staff on duty had a good understanding of identifying and responding to potential abuse including reporting procedures. Staff including ancillary and agency staff could identify the designated person to manage allegations of abuse and information on reporting procedures was clearly on display in the designated centre. Of the safeguarding plans in place, these were regularly reviewed and staff had a good understanding of these plans. Residents appeared relaxed and comfortable in the presence of staff. While inspectors found that staff were predominantly task orientated in the delivery of care to residents, when staff had time to interact with residents they did so in a warm and caring manner.

Inspectors found that there was poor governance arrangements for the monitoring of safeguarding plans. These plans are an important aspect in responding to identified safeguarding risks for residents and are required as part of the national safeguarding policy. The recent six monthly review carried out by the provider stated that there were 20 safeguarding plans in place. On the day of inspection, the designated officer who had responsibility for developing and monitoring the safeguarding plans told inspectors that the centre had 12 active safeguarding plans. When this was reviewed with the person in charge and staff, they were only aware of nine active safeguarding plans.

Inspectors found that residents were not protected from self injurious behaviour (SIB) and that the agreed staffing requirements of some residents were not in place to ensure that residents were safe at all times. Inspectors found the arrangement for reporting of and responding to SIB required improvement. The person in charge and a behavioural support specialist stated that all incidents of SIB would be reported through the centre's adverse events procedures and that these incidents would help to inform the review or the priority of referral for behavioural support. However, staff on duty were not aware of this and produced a document which stated that they were not required to report incidents of SIB through the centre's adverse events system, and instead, record these incidents at a local level. Inspectors found that this lack of clarity of reporting and review of SIB negatively impacted on the care that residents received and resulted in a delay in assessment for behavioural support. An inspector also observed that a resident who required one-to-one staffing was left by themselves for a period of time, during this time the inspector became concerned for the safety of this resident who was attempting to entangle themselves in leads from appliances located on the unit. The inspector brought this to the attention of staff on duty who stated that they were unable to support this resident at all times due to a staff shortage on one of the days of inspection.

Inspectors found that 'as required' medication protocols had been introduced in the week prior to the inspection, for those residents who may require the support of chemical interventions in response to SIB. 'As required' protocols stated that staff need to be aware of proactive and reactive strategies to support the residents. However, a behavioural support plan was not in place to guide staff in proactive and reactive strategies on the day of inspection. This was brought to the attention of the behavioural support specialist who then finalised a behavioural support plan, which was in draft format and had not been available to staff. The protocol also stated that if the medication was administered three times, then the administration of this medication required review. Inspectors found that medication had been administered on numerous occasions without being reviewed as required by the protocol. When asked, staff stated that it was their understanding that the medication was to be reviewed following three administrations within 24 hours, however this was not stated on the protocol.

Staff had a good knowledge of residents' behavioural support plans, including proactive and reactive strategies, where these were in place. However, not all staff were up-to-date with training in regards to the management of behaviour that is challenging.

The centre maintained a log of restrictive practices which was regularly reviewed and audited by the provider. However, inspectors found that consent for the use of these therapeutic interventions had not been sought from the resident or their representative.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
On the day of inspection, inspectors found that the provider maintained a record of all incidents and submitted notifications to the Health Information and Quality Authority (HIQA). However, inspectors noted that some incidents which were identified on quarterly notifications to HIQA should have been submitted within three days of the incident occuring as stated in the regulations.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
There were no actions required from the previous inspection.

No residents residing in the centre were availing of training, education or employment at the time of this inspection. As per the centre's statement of purpose, if residents wished to attend education, training and development, this could be facilitated at the day activation centre. However, inspectors found no assessments were completed to identify what supports residents needed to access opportunities for education, training and employment, if they wished to access these outside of the day activation centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
In general, residents' healthcare needs were being met, and there was access to a range of allied health professionals.

Inspectors saw that nurses were aware of and responding to the healthcare needs of residents. Inspectors reviewed a sample of healthcare plans for residents and found that there were a range of plans to guide staff on meeting the healthcare needs of residents.

However, some of the healthcare plans were not sufficient and did not give adequate

guidance to staff. This was of a concern because there continued to be a reliance on agency staff who were not as familiar with residents.

Inspectors reviewed the healthcare plans for a resident who was in receipt of palliative care. The care plans were medically focussed and did not provide sufficient information on the spiritual and emotional well being of the resident. The care plan for a resident had issues with anxiety gave insufficient guidance to staff and was confined to an instruction to alleviate the anxiety without setting out how this was best achieved. One of the resident's reviewed had a significant healthcare condition but there was no care plan to guide staff on the management of the condition. However, staff did see that the resident was regularly reviewed in relation to the condition.

Registered nurses were also conducting an annual clinical audit of the care requirements of residents and implementing wound care plans as required.

Residents had access to allied health professionals such as speech and language therapists, physiotherapists and occupational therapists. Staff had made timely referrals to these professionals when a need was identified, and all prescribed recommendations following the review of residents had been implemented.

Residents were regularly reviewed by their general practitioner (GP) and professionals such as neurology, urology and orthopaedics. However, the provider had identified a risk to residents' welfare in regards to accessing their GP in times of illness. The provider had a risk assessment in place which stated that residents were unable to access their GP for one week in every month. The provider had rated this as a high risk. However, the provider had not appropriately addressed this and were reliant on emergency out of hour medical support should a resident require support in the week where no GP was available.

Food which was prepared for residents appeared nutritious and was consistent with the dietary requirements of residents. Staff were available to aid residents who required assistance and a choice of meals was available to residents. Residents also had access to snacks and refreshments throughout the day.

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):
Some action(s) required from the previous inspection were not satisfactorily

implemented.

Findings:
Inspectors found that there were appropriate medication practices in place. However, the action from the previous inspection had not been addressed. Inspectors found that improvements were required in relation to medication administration arrangements.

On this inspection, inspectors found that medication audits were now in place but had not been effective in identifying and managing medication management issues. Inspectors reviewed a sample of medication charts and found that the arrangements did not comply with the provider's medication management policy. Some medications did not have the route or frequency of administration included. Some medication charts did not contain photographic identification and a section for residents' known drug allergies was also incomplete.

A sample of medication administration recording sheets were also reviewed. Inspectors found that some administration records for short term medications were incomplete. One prescription sheet stated that a resident was to receive medication for ten days. However, the administration sheet indicated that the resident only received the medication on two days and did not contain any explanation for why the prescription had not been complied with. The same administration record indicated that the resident was away from the unit a number of days later, but this was not consistently recorded on all aspects of the administration recording sheet.

Inspectors found that 'as required' medications had protocols in place for their use. However, some of these protocols did not contain the maximum dosage to be administered in 24 hours, as stated on the resident's prescription sheet. It was also unclear as to when a resident should be reviewed following the administration of 'as required' medications.

Medications were stored securely and the keys for medication trolleys were held by the senior staff on duty. The provider and a pharmacist were conducting regular audits of medication storage and practices. There was a stock control system in place for all medications, including controlled drugs, which were delivered to the centre by a pharmacist.

Residents had been assessed to self-medicate; however, no residents were self-medicating on the days of inspection.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that the provider had not addressed the action arising from the previous inspection. At this inspection, it was found that improvements were still required to the centre's statement of purpose to ensure it met all requirements as set out in Schedule 1 of the regulations, including:

- the specific care and support needs that the designated centre is intended to meet
- The review of residents' personal plans, in light of any changes to the residents' support needs
- The arrangements for residents to attend education, training and development
- The emergency procedures in the designated centre associated with the fire precautions.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that the provider's governance and management arrangements were not effective in monitoring the safety and quality of the service. They were failing to adequately identify service delivery issues for themselves and failing to put measures in place to manage those issues. In addition, inspectors found that where issues had been identified, the provider had identified actions to bring about improvement but those actions had not being implemented. Inspectors found that the provider's management

systems did not effectively monitor and ensure the centre was in compliance with regulatory requirements and that the residents' assessed needs were being met. In particular, inspectors found poor governance in regards to safeguarding plans within the centre.

Overall, inspectors found that the designated centre was not appropriately managed or governed to ensure that residents received a safe and quality focused service. Inspectors found on this inspection that the provider had failed to effectively implement their own action plan in response to the previous monitoring inspection and that 20 of the 27 actions had not been addressed. Inspectors also found that the compliance with the regulations in a number of outcomes had deteriorated since the last inspection and this level of deterioration was having a negative effect on the care provided to residents in areas such as the rights, dignity and consultation of residents, safeguarding, resources and workforce.

Inspectors found that the provider and person in charge had failed to implement all recommendations of a report generated by a fire consultant, within the agreed timescales. On inspection, the provider representative stated that this timeline would not be achieved and that a revised schedule of works was in place and due to be completed by September 2017.

The provider had completed an annual review of the quality and safety of care and support in the centre. The report of this review examined all 18 outcomes and detailed trends within the care provided. Action plans had also been developed specifically in areas such as safeguarding, management of falls and the management of behaviours that may challenge. However, inspectors found that these action plans were ineffective as there had been no delegation of responsibility for the actions required or timeframes in which to address the identified areas for improvement. Inspectors found that the annual review of the services had also highlighted many areas for improvement, however, the provider again failed to delegate responsibility and timeframes to address the areas which required improvement. The annual review also failed to clarify how residents and their representatives were consulted in the formulation of this report.

The provider had completed a six monthly unannounced visit and produced a report on the safety and quality of care. However, this visit was not carried out within the required timelines. While the action plan developed as a result of this visit had identified the people and timelines to address issues raised, it failed to clearly identify the actions to be taken.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
On the days of inspection, the provider had a clear management structure in place. Inspectors found that there were arrangements in place to cover the absence of the person in charge both during planned absence and out-of-hours. The centre was based in a campus setting which had a manager on-site at all times.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
Inspectors found that the provider had not ensured that the designated centre was adequately resourced to meet the assessed needs of residents.

Following the previous inspection, the provider submitted an action plan which stated that the unplanned leave of staff had impacted on the ability of the provider to meet the social needs of residents. The provider also indicated that they were having issues with the recruitment and retention of staff, which meant that the centre was reliant on agency staff. The provider stated in the action plan that they would recruit the required additional staff by 30 April 2017. Inspectors found that the provider had recruited five additional care assistants since the last inspection. The provider also stated that the reliance on agency staff would reduce as residents transitioned to community based services over the coming two years. However, inspectors found that these measures were having little impact on improving the quality of care provided to residents.

Overall inspectors found that the centre was under resourced to deliver a good quality of care to residents.Throughout the course of the inspection, staff stated and records indicated that residents were not engaged in meaningful activities and had inconsistent and limited access to their local community. In addition inspectors found that an

insufficient number of staff were available to deliver all aspects of personal planning, including the implementation of positive behavioural support plans. Staff also reported that the activation team would regularly have to assist residents with their care needs as opposed to their social activities, for which they were employed.

On one of the inspection days, the centre was operating below the required minimum staffing described on the roster, as a staff member was on unplanned leave. Inspectors found that the provider had no contingency plan in place for such occasions and that this impacted the quality of care delivered to residents on that day.

The centre also had a number of wheelchair users. Inspectors found that the transport provided could only accommodate one wheelchair user at a time and therefore limited the large number of other wheelchair users from accessing the community.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found that improvements were required to the number and skill mix of staff. Three of the four actions from the previous inspection had not been satisfactorily implemented and remained non-compliant on this inspection. One action in relation to staff support and supervision had been effectively implemented since the previous inspection.

Inspectors found that the provider's workforce arrangements were not effective, and where actions had been agreed to improve these, they were not completed within agreed deadlines. In addition, inspectors found that there continued to be a lack of appropriate training, recruitment, allocation of resources and skill mix in line with the regulations, throughout the designated centre.

Inspectors found that low staff numbers was having a negative effect on the quality of life for residents in the centre. From reviewing residents' personal plans it was evident

that the centre did not have enough of staff on duty to meet residents' needs. One resident's behavioural support plan stated that they required a walk and a meaningful outing everyday. However, records indicated this resident did not have a meaningful activity for 10 out of 20 days. Staff on duty stated that this resident would always go for a walk but a lack of staff numbers meant that this resident would not access the community on a daily basis. The provider had recruited five additional care assistants since the previous inspection. However, inspectors found that the recruitment of these additional staff had only had a limited impact in terms of providing for increased social care activities for residents.

Improvements continued to be required in regards to staff files. Inspectors reviewed a sample of staff files and found that Schedule 2 documents to indicate that the person was suitable to work with vulnerable people were not available and these included Garda vetting, employment histories and written references.

Inspectors reviewed staff training records and found that sufficient numbers of staff had not received training in manual handling and responding to behaviours that challenge. The inspector noted that the timeline for completion of this action had not been reached on the day of inspection and records indicated that little progress had been made towards training these staff.

Judgment:
Non Compliant - Major

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

Theme:
Use of Information

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

Findings:
Inspectors found that improvements were required to the maintenance of Schedule 3 documents and to the directory of residents, as required by the regulations.

Inspectors reviewed a sample of Schedule 5 policies and procedures available at the centre during the inspection. Overall, these were found to be up-to-date, accessible to

staff and met the requirements of Schedule 5 of the regulations.

There was a directory of residents which detailed information in accordance with Schedule 3 of the regulations. However, the inspectors found some gaps in the recording of the name, address and telephone number of some residents' General Practitioners.

Overall, residents' records were compliant with Schedule 3 of the regulations; however, gaps were identified in the recording of occasions where chemical interventions were used in respect of residents to include the reason for its use, the intervention tried to manage the behaviour and the duration of the restrictive procedure

Inspectors found that the centre maintained a copy of the current statement of purpose, residents' guide and all previous inspection reports in accordance with Schedule 4 of the regulations. However, inspectors found that gaps were identified in the records required to be held in line with schedule 4, including:
- records of all complaints made by residents and the action taken by the registered provider in respect of these complaints
- records of the food provided for residents in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003321
Date of Inspection:	16, 17, and 18 May 2017
Date of response:	11 August 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put in place arrangements to ensure that each resident has the freedom to exercise choice and control in his or her daily life.

1. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the

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

freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
An apology has been issued to all individuals, where ipads have been purchased for them without consultation. In addition if this type of assistive technology is deemed inappropriate for any individual, all associated funding will be reimbursed to them.

Individuals and their representatives will be fully consulted regarding all significant future purchases which relate to individuals. Evidence will be provided that this consultation process has taken place through, minutes of meetings, phone call notes, letters. All staff have been made aware of the importance of the consultation process to ensure that their wishes and choices are respected.

The assessment process for this type of assistive technology entails a review of existing appropriate assessment tools and agreement on the most relevant one. Following this, a plan of individual assessment schedules will be agreed. Managers have identified 21 individuals who require an assessment. The process will involve the staff MDT, the SaLT, occupational therapist and psychologist. The assessments will be completed by the 31st of October, completion will be overseen by the manager of the centre The assistive technology solutions for residents who have communication needs will be explored and documented by the Speech and Language Therapy service, following individualised assessments in terms of the potential suitability of use of Augmentative and Alternative Communication AAC systems to support communication (which may include no tech, low tech or high tech communication solutions). To date 8 AAC assessments have been completed in this centre by the SaLT.

Proposed Timescale: 31/10/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that each resident's privacy and dignity was respected through:
- adequate privacy screening in shared bedrooms
- ensuring residents' dignity is maintained at all times at residents' meetings.

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:
The issue of adequate privacy screening is being addressed through the use and movement of fixed particians this will eliminate the requirement for mobile screens. The

centre remains closed to long term care admissions. Rooms where there are three-four beds are being targeted initially. Currently, this centre has 6 three bedded rooms. The three bedded rooms are being reconfigured to afford a greater level of dignity and privacy to the people in these rooms. All staff in the centre have been reminded of the importance of ensuring that privacy screening in shared rooms is adequate at all times. As beds become vacant they are being removed from the centre to ensure that the numbers of people living in this centre are permanently reduced.

To ensure that residents residents' dignity is maintained at all times the centre has commenced a person centred cultural, learning program commenced in March 2017 and will run for a year. To support the program a manger from the centre is involved in rolling out this program with 11 person centred culture champions (including the provider and three front line staff from C1) who are receiving monthly training in this area until February 2018. The purpose of the program is to focus on our values as individuals, how we value the individuals that we support and how we incorporate these values into every day practice. Learning from observations and audits of practice and a focus on the use of non-person centred language are two examples. Support and supervision sessions are also being completed by managers with frontline staff through meeting with them individually on a monthly basis.

Proposed Timescale: 30/11/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that each resident consented to decisions about his or her care and support in relation to the purchase of assistive technology.

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

Please state the actions you have taken or are planning to take:
An apology has been issued to all individuals, where ipads have been purchased for them without consultation or consent. In addition if this type of assistive technology is deemed inappropriate for any individual, all associated funding will be reimbursed to the individuals.

Individuals and their representatives will be fully consulted regarding all significant future purchases which relate to individuals. Evidence will be provided that this consultation process has taken place through, minutes of meetings, phone call notes, letters. All staff have been made aware of the importance of the consultation process.

A FETAC Level 3 in Assistive Technology programme has been sourced. A group of residents will be availing of this training in line with their personal goals. At the end of

the course, individuals will be asked to give feedback to improve the programme for other residents going forward. One of the Community Connector teams is taking a lead on this programme.

Proposed Timescale: 31/10/2017

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that each resident had adequate secure storage space to maintain their personal property and possessions.

4. Action Required:
Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.

Please state the actions you have taken or are planning to take:
A review of the provision of secure storage places for each individual resident in the Centre has been completed by the centre manager and the maintence department. This is determining the additional provision of space and the security that is required for individuals in this centre. Each resident will be provided with a locked personal space in which to store their personal property and possessions should they wish to do so.

Proposed Timescale: 31/10/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that complaints made during residents' meetings were investigated promptly.

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

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

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the nominated person maintained a record of all complaints, including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

Please state the actions you have taken or are planning to take:
A record of all complaints is now being maintained by the complaints officer for all complaints or concerns from individuals, verbal or otherwise during or independent of meetings regarding any aspect of service provision.

This record includes the investigation of the complaint the outcome of the complaint, action taken following the complaint and whiter or not the resident was satisfied with the outcome. If the resident is dissatisfied with the outcome how and to whom it has been escalated. A clear escalation/appeals pathway will be made available for individuals in this centre.

This information forms part of the complaints audit which is completed monthly and presented by the PIC at steering group meetings and will be shared with the resident forum group.

Complaints are audited on a three monthly basis by the General Manger to ensure that that trends, gaps and learning are identified from analysis of Complaints Audit.
In addition a person centred culture, learning program commenced at the service in March 2017 and will run for a year, with a view to running subsequent programs. A manger from C1 is involved in rolling out this program. The purpose of the program is to focus on our values as individuals and how we value the individuals that we support. How we listen, understand and respect the opinions of the individuals that we support.

Proposed Timescale: 30/09/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that each resident had access to the internet.

7. Action Required:

Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

Please state the actions you have taken or are planning to take:
Internet will be provided by the Provider while a permanent IT solution is being resourced Residents will continue to use personal dongles which will be paid for by the Provider.

Proposed Timescale: 31/10/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that residents were supported to use assistive technology.

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

Please state the actions you have taken or are planning to take:
The assistive technology solutions for residents who have communication needs will be explored and documented by the Speech and Language Therapy service, following individualised assessments in terms of the potential suitability of use of AAC systems to support communication (which may include no tech, low tech or high tech communication solutions).
Resident communication support plans will be reviewed with keyworker staff by the Speech and Language Therapy service.
An audit of the quality of Communication Passports completed will take place with support and documented feedback to keyworker staff from the Speech and Language Therapy service.
Training 'Supporting the communication needs of adults with intellectual disabilities' is mandatory and scheduled on site quarterly by the Speech and Language Therapy service.

Staff will be facilitated to attend the training and a record of attendance will be maintained next training dates have been arranged for the 30th and 31st of August .

A programme has been sourced FETAC Level 3. A group of individuals will be availing of same in line with their personal goals. A member of the community connection team will be supporting this process.

Proposed Timescale: 30/11/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the written agreement for the provision of services included details of the services to be provided for that resident in accordance with the fees charged.

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

Please state the actions you have taken or are planning to take:
A review of the service agreements has taken place and these were issued to individuals and their representatives in May 2017. These agreement clearly set out the weekly contributions and how they have been calculated.
The agreements were again reissued to residents and their representatives on the 17th July 2017. The service through key workers is following-up with individuals and their representatives to identify and address any concerns that they may have with the agreements. A template has been developed to capture return of completed, signed service agreements.

Proposed Timescale: 30/09/2017

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 provider failed to ensure arrangements were in place to at all times meet the needs of residents with:
- assessed social care needs
- assessed one to one staff support needs

10. 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:
The action plan submitted by the provider does not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this action plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that an appropriate social care needs assessment was carried out for residents who presented with dementia.

11. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
The service now has on its staff a part-time clinical psychologist who will be completing a number of assessments in relation to dementia. A number of individuals have been identified as requiring this assessment and are being referred.

Proposed Timescale: 30/11/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that residents' personal plans were available in an accessible format to the residents and, where appropriate, their representatives.

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

Please state the actions you have taken or are planning to take:
A copy of personal plans will be given to each resident.

The SaLT will support key staff to adapt personal plans so that they are available to residents in a suitable format.

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:
The provider failed to ensure that where residents were identified for transition to the community, that information on the services and planned supports required by the resident was available.

13. Action Required:
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

Please state the actions you have taken or are planning to take:
Transition plans will be revised by the transition team and amended to identify the services and supports that are required by each resident and these will be available in the Residents Personal File.

Proposed Timescale: 15/09/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises did not meet the requirements of Schedule 6 of the regulations in terms of privacy and the suitability of communal areas.

14. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
The HSE has committed finance to a program of fire compliance structural works which is currently underway and on target see attached Gantt chart. Incorporated into this plan is a schedule of painting, decorating, suspended ceiling upgrade which will enhance the living space. Individuals will be consulted and supported to enable them to make choices on the personalisation of their living areas. A central log of all agreed works and a flowchart of the quotations, approvals and completion dates is held in the Maintenance Office and reviewed with the PICs on a monthly basis.

The personalisation of the bedrooms and private areas will continue. Residents will be supported and consulted with on personal choices and wishes in these areas.

The centre remains closed to all long term care admissions.

In September 2017 when individuals from Centre 3 transition to the community individuals from Centre 1 will be supported to transition initially to on campus bungalow

accommodation, until their residences in the community are available.

Staff, the transition team and management are currently working with individuals and their representatives, including the national advocacy service regarding where in the campus these individuals would like to live and with whom. As an immediate action the restaurant is being used to support individuals at meal times.

A person centred culture, learning program commenced at the service in March 2017 and will run for a year, with a view to running subsequent programs. A manger from C1 is involved in rolling out this program. The purpose of the program is to focus on our values as individual staff and how we value the individuals that we support. How we listen, understand and respect their right to dignity, privacy and person centredness.

Proposed Timescale: 31/01/2018

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that all hoists were suitably serviced.

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

Please state the actions you have taken or are planning to take:
Since the inspection all hoists in this centre have been suitably serviced. A system has been established where the hoists will serviced and maintained as per the manufacturers specifications

An equipment register to include hoists has been established. All documentation in relation to services will be available for future inspections. Where there is no documentation that hoist was serviced, the contractor will be brought in to service same.

Proposed Timescale: 20/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that water damage to ceiling panels had been repaired.

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

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

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

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that kitchen facilities were accessible to all residents in the designated centre.

17. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
Currently the kitchen facilities are not accessible in one part of the centre. Having explored a possibility of creating an accessible kitchen for all individuals and in consultation with Catering Department. It is not feasible, to access this kitchen area in the immediate vicinity. However residents have access to snacks and drinks of their choice at all times. There are kitchens in other areas of the service where individuals are getting involved in cooking and baking.

Residents in the remainder of the Centre have full access to the kitchen and are supported to access same.

Proposed Timescale: 31/8/2017

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:
The provider failed to ensure that there were effective management systems in place.

The provider failed to ensure that
-fire risk assessment had been amended following failings which were identified during recent fire drills.
-risk assessments for MRSA included appropriate control measures.

18. 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:
All fire risk assessments have been amended following any failings which were identified during fire drills.
Risk assessments for MRSA are complete. Advice and support was sought from the Occupational Health Department Galway and measures were put in place including appropriate control measures.

To support the governance of risk in the centre a new Quality and Patient Safety Manager has been appointed to the CHO2 area to oversee risk. A Risk Advisors has been assigned to the service. Part of their remit will be to oversee risk management in Aras Attracta and to implement the 2017 HSE Integrated Risk Policy. In addition support will be provided in the area of risk management, hazard identification, assessment of risk, control measures and education for all staff. A local Quality Patient Safety Committee will be set up to ensure appropriate review and updating of all Risk Management Policies Procedures and Guidelines. The Committee will monitor all aspects in relation to, falls, fire, including panic alert & pager systems and evacuation plans and training. All incidents / accidents are triaged 3 times per week at the local Incident Report Forum. Serious incidents are escalated to the weekly CHO2 Serious Incident Committee minuted teleconference every Thursday. In addition there are monthly QPS oversight meetings.

Risk registers under review currently and will be reviewed monthly at the local QPS meetings.

Two staff member have been identified and trained as a Hand Hygiene Instructor. Hand Hygiene training commenced the week 10th July 2017 and is planned for the coming months. All staff will be trained by 31st December 2017.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the risk management policy clearly identified how risk would be assessed throughout the designated centre.

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

Please state the actions you have taken or are planning to take:
The centre is implementing the HSE 2017 Integrated Risk Policy. This identifies how risk would be assessed throughout the designated centre. In addition to support the governance of risk at Aras Attracta a new Quality and Patient Safety advisor has been appointed to Aras Attrcta to oversee risk. Part of their remit will be to oversee risk management in Aras Attracta and to implement the 2017 HSE Integrated Risk Policy. This included a review of the risk management, hazard identification, assessment of risk, control measures and education for all staff in this area.

Proposed Timescale: 31/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the risk management policy clearly identified the measures and actions in place to control identified risks.

20. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
The centre is implementing the HSE 2017 Integrated Risk Policy. This identifies how risk would be assessed throughout the designated centre. In addition to support the governance of risk at Aras Attracta a new Quality and Patient Safety advisor has been appointed to Aras Attrcta to oversee risk. Part of their remit will be to oversee risk management in Aras Attracta and to implement the 2017 HSE Integrated Risk Policy. This included a review of the risk management, hazard identification, assessment of risk, control measures and education for all staff in this area. The risk management policy is currently under review and will be amended to reflect the controls required to reduce the level of risk.

Proposed Timescale: 31/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that appropriate infection control procedures were in place.

21. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
A risk assessment pertaining to MRSA is complete. Advice and support was sought from the Occupational Health Department Galway and measures were put in place.

Infection Control policy in place with hand hygiene training schedules rolled out for all staff. Two staff members has been identified and trained as Hand Hygiene Instructor to support this.

Hand Hygiene training commenced the week 10th July 2017 and is planned for the coming months and will be completed with the time lines. All cleaning staff have been provided with a copy of the HSE Infection Control guidelines in relation to cleaning. They have confirmed in writing that they have read and understand them. Infection control audits have taken place to ensure compliance with the policy.

Proposed Timescale: 31/10/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the centre had adequate emergency lighting.

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

Please state the actions you have taken or are planning to take:
The HSE has committed finance to a program of fire compliance structural works which is currently underway and on target see attached Gantt chart. Incorporated into this plan is a schedule which incorporates emergency lighting. There are awake night staff in all areas of this centre and fire risk assessments in place.

Proposed Timescale: 31/01/2018
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect: The provider failed to ensure that staff had appropriate equipment and staff numbers to evacuate all residents from the designated centre.

23. 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:

Evacuation and egress plans have been reviewed and updated. New wheelchairs have been sourced, are in place and checked daily. There is now sufficient equipment to safely evacuate residents in the event of a fire.

There are adequate number of staff available to evacuate residents both during the day and at night. Regular fire evacuation drills are completed in the centre with identified locations known. A personal emergency evacuation plan is available for each resident in this centre. This is regularly reviewed and updated to reflect the changing needs of each individual.

The health and safety folder in the centre includes a fire register and daily checks are in place to maintain safety in relation to fire.

Proposed Timescale: 31/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that personal emergency egress plans included the required arrangements to evacuate all residents from the designated centre. The provider also failed to ensure that staff had received training in reading an newly installed fire panel.

24. 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:
There are now personal emergency egress plans which include the required arrangements to evacuate all residents from the designated centre. Fire training is mandatory for all staff. Currently all of staff in this centre have received their fire training. All centre induction, fire training and fire drill sessions now include information on the fire panels in this centre. A training calendar is available for training sessions which have been arranged up until December 2017 to ensure that for all staff training in fire remains up to date.

Proposed Timescale: 30/07/2017

Theme: Effective Services

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

The provider failed to ensure that fire doors were in place in the designated centre.

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

Please state the actions you have taken or are planning to take
The HSE has committed finance to a program of fire compliance structural works which is currently underway and on target see attached Gantt chart. Incorporated into this plan is a schedule of works to replace current fire doors in the designated centre.
This centre has awake night staff in all areas and fire risk assessments.

There are adequate number of staff available to evacuate residents both during the day and at night. Regular fire evacuation drills are completed in the centre and per the regulations.

A personal emergency evacuation plan is available for each resident in each area of the centre. This is regularly reviewed and updated to reflect the changing needs of each individual.

The health and safety folder in each centre which includes a fire register and daily checks are in place to maintain safety in relation to fire.

Proposed Timescale: 31/01/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that therapeutic interventions had been implemented with the informed consents of residents or their representatives.

26. 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:
All restrictive practices will be implemented with the informed consent of each resident, or his or her representative, and are being reviewed as part of their personal planning process. An audit will be completed in the centre to track the progress of this action and this will be monitored by the PIC and fed into the QPS committee.

Proposed Timescale: 31/10/2017
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the criteria for the review of chemical interventions had been clearly documented.

27. 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:
A review of all PRN Protocols will take place in the Centre to establish that all protocols match prescriptions and are clearly documented. This is being completed by the CNS and will be completed within the time scale.

Proposed Timescale: 30/09/2017
Theme: Safe Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that appropriate systems were in place for the referral and review of positive behavioural support plans.

28. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour

Please state the actions you have taken or are planning to take:
A new referral system has been introduced since 22nd May 2017 by the CNS in Behaviours that Challenge called the FIS referral (Finding and implementing solutions). This is a detailed referral system.
An audit of practice report to be completed by 30th September 2017, by the CNS in Behaviours that Challenge this will include every BSP in the service. This will be

followed by a detailed SMART action plan.

Area by area reviews of all plans will be conducted by the CNS in Behaviours that Challenge: 3 review days (one per area) is scheduled for completion on October 31st 2017. All plans will then be reviewed quarterly or more frequently if required

Proposed Timescale: 31/10/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that all staff had received training in the management of behaviour that is challenging.

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

Please state the actions you have taken or are planning to take:
The service now has three staff who are trained locally as train the trainers in Studio 111 to provide training. The training includes the management of behaviour that challenge including de-escalation and intervention techniques. A schedule of training is in place to ensure that all staff have completed this mandatory training within the timeframe. All mandatory training records are reviewed on a monthly basis through the local QPS Committee, to ensure that targets are being met to ensure that all staff in the service are trained.

Proposed Timescale: 31/12/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that
- an accurate record of active safeguarding plans was in place
- residents were protected from self injurious behaviour
- staffing arrangements were in place to meet the assessed needs of residents

30. 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:
An accurate record of active safeguarding plans is now in place. Staff managers and the

designated officer are now clear on the number of active plans that are in place. This is now a standing item on every handover. In addition the themes of the safeguarding concerns from the centre are reviewed on a monthly basis to identify patterns when and how they occur.

Promoting a culture of learning and developing a safeguarding culture, there is also Incident Review Meetings during the working week (Monday Wednesday and Friday morning). These meeting are attended by both the designated officer and the CNS in behaviours that challenge. This meeting is designed to triage incidents and to identify what is identified as an abusive or a behavioural concern.

Following the Incident Review Meeting, the Designated Officer and/or the CNS in Aras Attracta will act immediately to investigate or review the cause of harm/ injury/ self injury, which has occurred without delay. This investigation is in line with best practice and involves working closely with staff operating in the accommodation and the individual requiring the support.

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

Proposed Timescale: 31/08/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that HIQA was notified within three days of an injury which was sustained by residents in which medical treatment was required.

31. Action Required:
Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Please state the actions you have taken or are planning to take:
All notifiable events will be completed and notified to the Authority in line with the regulations.

The PIC will ensure that all notifications are submitted to the authority within the designated timeframes.

A log is maintained in the centre of all notifications submitted and follow up time lines.

Proposed Timescale: 30/05/2017

Outcome 10. General Welfare and Development

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Provide each resident with appropriate care and support to access education, training and development in accordance with their assessed needs.

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

Please state the actions you have taken or are planning to take:
Through discovery and exploration each resident will be supported to identify their own interests and assets. This will contribute to areas of opportunity for each resident to achieve highly valued social roles and can therefore identify choices for education, training and employment.

The occupational therapist will support key workers to complete formal and informal assessments with each individual that will identify education training development employment goals/objectives with each person. Based on the findings goals in this domain will be identified in the persons individual personal plan.

Proposed Timescale: 31/12/2017

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:
The provider failed to ensure that end of life care planning accounted for the spiritual needs, and the rights and wishes of residents.

33. 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:
As part of a comprehensive care planning process, where there is an identified need, the area of end of life care planning will be broadened with each individual and their representative in a sensitive and respectful manner by key working staff. In these plans there will be a greater focus on the rights, wishes, preferences and the psychological

and spiritual needs in all end of life care areas. Which where there is an identified need, these aspects are documented.

Proposed Timescale: 30/10/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that
- each medication chart had the resident's photographic identification in place
- each medication chart contained the route and frequency of administration
- each medication chart contained completed information on residents' drug allergies
- all medication administration records were completed
- 'as required' protocols were in line with prescription sheets

34. 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 review of all medication charts in the centre was conducted following the inspection. Any chart in the centre without an individuals photographic identification now has one and this situation has been addressed. All medication charts now contain the route and frequency of administration. All medication charts now have completed information on residents' drug allergies which are included on all medication records. 'As required' Protocols are being reviewed by the CNS to confirm that they are all in line with prescription sheets. Medication audit templates will be reviewed to ensure that they are measuring compliance with regulatory requirements and being completed in line with best practice. All audits will be reviewed by the Quality and Patient Safety Committee on a monthly basis.

Proposed Timescale: 30/09/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities)

Regulations 2013.

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

Please state the actions you have taken or are planning to take:
The Statement of Purpose will be reviewed, to contain information on the specific care and support needs that the designated centre is intended to meet
- The review of residents' personal plans, in light of any changes to the residents' support needs
- The arrangements for residents to attend education, training and development
- The emergency procedures in the designated centre associated with the fire precautions.
In addition the Statement of Purpose will be reviewed and provided in an easier read more accessible format with support from the SaLT.

On completion a copy of the updated Statement of Purpose will be submitted to the authority.

Proposed Timescale: 31/08/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review failed to clarify how residents and their representatives were consulted in its formulation.

36. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
There is an annual review of quality and safety of care in the designated centre.

Through the family forum meetings with and service satisfaction survey/questionnaire, insights are gained from families about the quality and safety of care and support. These will be profiled and included in the annual review by the PIC.

A copy of the annual review will be made available to residents in an accessible format and displayed in a prominent place for residents to access.

Proposed Timescale: 30/10/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review failed to delegate responsibility and set timeframes to address the areas which required improvement.

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

Please state the actions you have taken or are planning to take:
An action plan based on the 18 outcomes will be produced by the PIC as part of the Annual Review and will have associated persons identified. These will be reviewed by the QPS committee.

Proposed Timescale: 31/10/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to clearly detail the actions required to address deficits which were identified when completing the six monthly audit of the safety and quality of care and support in the centre.

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

Please state the actions you have taken or are planning to take:
The Chief Officer or a Delegate will complete 6 monthly audits. An action plan will be drawn up by the DoS where there are shortcomings and these will be integrated into the annual review action plan. The Centre will implement within the timeframe and these actions will be monitored at the QPS committee to ensure that they are completed. Any issues of concern not addressed will be escalated or a rationale provided

Proposed Timescale: 30/11/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to effectively implement the action plan generated from the previous report within agreed timelines

39. Action Required:
The Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The PIC meets with their staff and management team fortnightly to monitor the progress of the action plan.

The QPS committee will monitor the action plan monthly to ensure that they are completed within the times frames. Any issues of concern not addressed will be escalated or a rationale provided.

The local senior management team have bi-weekly minuted management meetings to monitor the progress of action plans with actions assigned and named persons responsible.

Proposed Timescale: 30/10/2017

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the centre was adequately resourced to meet the needs of residents.

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

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

plan and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that skill mix and numbers of staff met the assessed needs of residents.

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

Please state the actions you have taken or are planning to take:
A staffing review has been completed and skill mix has been identified in order to effectively manage the Centre. This process requires the relocation of some grades of staff who will be transferred into the Centre. Community Connectors Team are being re-establish to provide meaningful activities to meet the assessed social care needs of residents. Where there has been an assessed one to one staff support requirement, this is being provided on a consistent basis.

Proposed Timescale: 30/10/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that all requirements of Schedule 2 were in place.

42. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
A full review of all staff files has been completed in Centre 1 to ensure that these files now all meet the requirements specified in Schedule 2 of the regulations. The documents are now being prioritised for collection by the administration department, for all staff directly employed by the HSE at the service and contracted agency, catering, cleaning and transport staff.

The Person in Charge will complete quarterly audits to ensure Schedule 2 information and documents remain in place for all staff.

Proposed Timescale: 30/09/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that all staff were up-to-date with training needs.

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

Please state the actions you have taken or are planning to take:
A planned training schedule has been devised in line with the residents needs including all of the centres mandatory training obligations. A the provider is committed to ensuring that staff will be provided with time to attend this training and to ensure that all staff receive their mandatory training and are kept up to date within the time frame.

Proposed Timescale: 31/12/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure the directory of residents included the name, address and telephone number of each residents' General Practitioner as specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

44. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
A review of the Directory of Residents has been undertaken and it now includes the name address and telephone number of each residents General Practitioner the requirements as outlined above. Clear responsibility has been identified with administration to update the register when there are any changes to it.

Proposed Timescale: 31/07/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to maintain, and make available for inspection by the chief inspector, records in relation to any occasion on which chemical restrictive practices were used in respect of the resident as as specified in Schedule 3.

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

Please state the actions you have taken or are planning to take:
A review of all PRN Protocols including chemical interventions will take place in the Centre by the CNS to establish that the protocols contain, the reason for its use, other interventions that have been used before the chemical intervention is used, the maximum dosage to be administered in 24hours. The action plan from this review will be presented to the PIC for overall inclusion in the overall action plan. In addition all restrictive practices are implemented where with the informed consent of each resident, or his or her representative, and are being reviewed as part of their personal planning process.

Proposed Timescale: 30/09/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that all records required under schedule 4 were made available for inspection.

46. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

Proposed Timescale: