

eDeposit Ireland

Glenbow

Item Type	report
Authors	Connolly, Jillian;Glynn, Catherine
Citation	Jillian Connolly, Catherine Glynn, 'Glenbow', [report], Health Information and Quality Authority, 2016-12-16, Disability Services Report, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-03-13 05:10:38
Link to Item	https://hdl.handle.net/20.500.14765/81131

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Glenbow
Centre ID:	OSV-0003364
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	Jillian Connolly
Support inspector(s):	Catherine Glynn; Michelle McDonnell
Type of inspection	Unannounced
Number of residents on the date of inspection:	42
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
02 August 2016 12:30	02 August 2016 20:30
03 August 2016 10:00	03 August 2016 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the fourth inspection of this centre. During the previous inspection in March 2016, inspectors found that there had been poor progress by the provider in implementing their own action plan to improve the quality of the service for residents. Inspectors found that there was inadequate governance and oversight of the centre, and residents continued to have a poor quality of life. The provider had failed to ensure that appropriate arrangements were in place to ensure the safety of residents and that residents had a good quality of life. Following that inspection, HIQA took the unusual action of issuing the provider with a formal warning letter.

Following on from the inspection in March 2016, three regulatory meetings were held with senior management of the Health Service Executive to discuss the requirement for effective change in this centre and also the governance and management of all

designated centres in that area. The provider submitted a plan for the reconfiguration of centres and to address the deficits in the governance and management systems.

The purpose of this inspection was to identify if the quality and safety of service provided to residents had improved since the previous inspection.

How we gathered our evidence

As part of this inspection, inspectors spent time with residents. Inspectors also met with staff, observed practices and reviewed documentation such as residents' personal plans, health and safety documentation and audits. Management and staff facilitated the inspection.

Description of the service

The designated centre is a campus based setting located in Co. Sligo. Services were provided to male and female residents, who had a primary diagnosis of an intellectual disability. All residents were over the age of 18. The centre is operated by the Health Service Executive. This inspection involved the units in the main building.

Overall findings

Although the provider had taken some action since recent inspections, inspectors found this had not impacted positively on the quality of life for residents. Overall the inspectors found the provider had failed to ensure that the service provided was, appropriate to residents' needs, consistent and effectively monitored. Inspectors found that:

- Residents, for the most part, led passive lives with minimal interaction with their local community and surrounding areas.
- Residents spent the majority of their time at the centre, leaving the centre on a weekly or fortnightly basis.
- Residents did not exercise choice and control regarding their daily routine.
- The quality and safety of care provided to residents was dependent on the competence of individual staff members.
- Staff engaged with residents in a caring manner, however improvements were required to ensure that practices promoted the privacy and dignity of residents.
- Staff interactions with residents, were in the main, task orientated and based around direct care.
- The environment failed to meet the needs of residents.

Considering the cumulative findings and the insufficient oversight of the centre, inspectors found that the governance and management arrangements were ineffective. Management arrangements failed to adequately identify lines of authority and accountability. Therefore there was an absence of identified responsibilities for all areas of service provision. There was an absence of appropriate monitoring, review and auditing of the care and support provided to residents. The variances in practice throughout the four individual units observed by inspectors further demonstrated an absence of appropriate governance to ensure effective delivery of service.

Inspectors also found it challenging to ascertain the assessment and decision making process regarding the allocation of resources such as staffing levels and training.

Residents who chose to engage with inspectors, expressed satisfaction with the service they received.

Inspectors identified major non-compliance in 10 of the 14 outcomes inspected.

Within this report, the inspection findings are presented under the relevant outcome. The action plan at the end of the report sets out the failings identified during the inspection and the actions required by the provider to comply with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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:

The inspectors found the provider had not ensured that the designated centre was operated in a manner that respected the rights, privacy and dignity of residents. Inspectors also found that residents had limited opportunities to exercise choice and control over their daily life.

The inspectors reviewed questionnaires completed by residents which demonstrated that the variety of food available did not adequately include residents' preferences such as fruit for drinks and 'minerals'. HIQA was informed that food choices would be discussed at residents' weekly meetings. However, a review of the documents stated that staff continued to check the cupboards and 'shop for goodies' as needed. The shopping was a shopping list completed by staff, as opposed to residents, to obtain food from the store cupboards on campus.

Inspectors found that some residents were not adequately facilitated to choose where and when they ate. Inspectors found that this was due to the environment and to coincide with the daily routine that was in place. For example, residents were supported to attend the dining area at specific times of the day. Main meals were provided by a central kitchen with a choice of two main meals. Residents were given the choice of meal in the morning and if they were not happy with that an alternative was made available. Inspectors found an improvement in food provisions being made available in the kitchens attached to three of the day rooms, including non-perishable items such as custard, fish and cereal. There were also products such as bread, yogurt and milk. Inspectors found there an absence of snacks/food in the day rooms.

The inspectors found that residents' choice of when to go to bed was also limited. Inspectors were informed that staff were deployed to specific areas to support residents to go to bed. This also resulted in residents being relocated to different units to await support to go to bed. Inspectors observed one resident in bed in a communal area, surrounded by a screen during the day. Inspectors found that this also compromised the dignity of the resident. Inspectors observed residents in their beds in the late evening. There was no assessment completed stating that it was a need for residents to go to bed early. Furthermore, due to the location of residents' living rooms, residents did not have free access to their bedrooms.

Inspectors observed that residents' privacy and dignity continued to be compromised. Some action had been taken since the recent inspection, for example screens had been placed on window panels on doors. However, practices observed by inspectors were not indicative of promoting the privacy and dignity of residents. On the first evening of inspection, inspectors observed residents to be in bed as the doors of residents' bedrooms were open. Inspectors also observed staff to use terminology which did not promote the dignity of residents, they included terms such as 'feeding' and 'toileting.' The provider had stated that staff would receive training in 'social role values' by the end of July 2016. This had not occurred.

Records did not support that the activities residents' took part in were in line with their interests and capabilities. Inspectors observed an increase in activities for some residents since the last inspection. However found that, in the main, they remained passive and did not evidence that they were in line with residents' interests and capabilities. Inspectors observed residents to spend a long portion of the day in their day room, with limited interaction. A review of daily records and an activity audit, which had been completed documented that activities included, walks, DVDs, exercises, massage, campus based mass, music therapy and relaxing on a mat. Some residents had not engaged in an activity for four to five days.

Furthermore inspectors found that residents were not supported to maintain control over their personal finances. Inspectors discussed with staff the system for residents' personal finances. Inspectors were informed that residents generally got 'pocket money' from the finance department on a weekly basis which staff collected. If additional monies were required they were requested from the finance department. Inspectors were informed that residents and or their representatives were not aware of residents' finances. Daily notes for one resident documented that a discussion had occurred between management, the finance department and staff regarding the purchase of razor blades for a resident, as the razors could not be purchased from personal pocket money. The resident and or their representative were not included in this discussion.

Inspectors reviewed the complaints record and were assured that it was managed in line with regulation 34. Of the sample reviewed, inspectors confirmed that the outcome of the complaint was clear and the satisfaction of the complainant recorded. This was an action from the previous inspection.

Overall, and as per the findings of previous inspections, inspectors identified that residents' opportunities to exercise choice and control in the care and support provided

to them continued to be limited. Residents' privacy and dignity, as previously found, also remained compromised. The provider had responded by implementing a variety of measures to the address this. However, inspectors found that these measures had minimal impact of improving the quality of life for residents.

Judgment:
Non Compliant - Major

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):

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

Findings:

Inspectors observed that there had been an increase in day trips for some residents since the last inspection. However, inspectors found that overall residents' links with the community continued to be minimal. For example, some residents attended a local hairdresser, however for other residents the hairdresser attended the centre. Shopping was obtained from the 'store cupboard' on campus. Residents were not involved in completing the shopping. Inspectors were informed by staff that residents could purchase 'treats' when attending outings. However leaving the campus remained infrequent; for some residents, this was a weekly or fortnightly activity. Daily records for one resident documented that they were supported to purchase snacks from the vending machine in the centre.

Staff and residents' personal records demonstrated that residents were encouraged to maintain links with family, through the purchasing of cards to send on occasions. Visitors were welcomed in the centre and the room allocated for visitors had recently been re decorated.

Judgment:
Non Compliant - Major

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

The provider had committed to ceasing admissions from 1 August 2015. This decision was in accordance with National Policy. Inspectors confirmed that the last admission was in July 2015.

In June 2015 and March 2016, two failings had been identified regarding the written agreements between residents and the service provider. Contracts had not been signed by both parties and the additional charges paid by residents were not identified. Inspectors were informed by the provider that the contracts had been amended and reissued to the representatives of relatives. The majority had been returned. Inspectors reviewed a sample and confirmed that they had been signed by representatives and included the additional charges that could be charged to residents. These were for reflexology, exercise, massage, seaweed bath and hairdresser.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Overall the inspectors found that residents were not assessed for all aspects of their needs, particularly their social care needs. As a result arrangements were not in place to meet the assessed needs of residents. These findings were reflective of previous inspection findings.

Inspectors reviewed a sample of personal plans. Inspectors determined that there was an absence of comprehensive assessment of residents' social care needs. Personal plans did not identify residents' needs to maximise their personal development in accordance with their wishes. In some instances, key workers identified goals for residents. Some residents were not involved in the setting of goals. The rationale for why some goals were identified by staff was based on their knowledge of the resident. This was not supported by a robust assessment.

The inspectors found that goals had been identified for residents. From a sample of the personal plans reviewed it was evident that goals were generally short term. Example of the goals included:

- going to the cinema
- going for a manicure
- going bowling
- going on a trip to knock
- going to a farm
- going to the beach.

Photographs had been taken of residents achieving some goals and reviews had occurred to ascertain the enjoyment level of the activity.

The inspectors reviewed residents' daily records which demonstrated that residents' opportunity to engage in these activities were infrequent. For example, three goals had been identified for one resident, all of which were day trips. The resident had been supported to achieve each of these goals within a two month period. Outside of the three days trips the resident had left the centre six additional times in this period, three of which were a 'bus spin' and three were listed as 'social outings.' There was a 13 day period in which the resident had not left the campus. Six of these days were spent in their day room.

Of the plans reviewed on this inspection, inspectors confirmed that in the main, plans had been reviewed following the last inspection. However, inspectors did observe a plan which had not been reviewed following a resident falling. Therefore it was not clear what action had been taken to prevent a reoccurrence.

The model of care provided in the centre was that there were registered nurses on duty at all times. Inspectors found that the assessments of residents' needs did not identify if they required full time nursing care. Therefore it was not clear that the supports provided to residents were in line with residents' assessed needs. Inspectors found that residents were being charged the maximum rate, as per their income, for individuals receiving in-patient services on premises where nursing care is provided on a 24 hour basis. This resulted in some residents having minimum income for personal expenditure. Inspectors determined that this limited their ability to engage in meaningful activities in the absence of a robust assessment stating what model of care and support they required.

Inspectors also noted that in the written agreements it stated that the additional fees to be paid by residents for the activities such as massage or reflexology were dependent on the choice or need of residents. Inspectors found that residents engagement in these

activities were not in line with their preferences or an assessed need.

Following the inspection March 2016, questionnaires had been issued to staff to ascertain their understanding of personal plans. The results of the questionnaires stated that staff had a good understanding of setting goals, however this was in contrast to the findings of inspectors. Furthermore, staff had stated in the questionnaires that they had not been provided with training on how to complete a person centred plan. This training and support had not been provided as of the inspection. An organization working group had been set up to review the template of personal plans. However, as demonstrated in this report the impact of this on residents' quality of life was negligible as of the day of inspection.

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 inspectors found incremental work had occurred to enhance the environment for residents inclusive of additional decor and furnishings, some of which was occurring on the day of inspection. However, fundamentally the layout and design of the centre did not meet the aims and objectives of the service and the number and needs of residents.

The centre consists of six individual residences, four located within a three storey building. There are also two separate bungalows, which were not inspected on this occasion.

Inspectors found the layout of the three storey building did not promote a homely environment as:

- Residents' bedrooms were located a significant distance from their living areas.
- Kitchenettes located in each unit were not appropriate to facilitate meals to be cooked in residents' homes. Therefore food was provided by a centralised kitchen.
- Toilets consisted of cubicles.
- Some bedrooms were located directly opposite the main entrance which resulted in anyone who entered the building (including visitors and administration staff) having

direct access to residents' bedrooms.

- Residents' bedrooms could be accessed from numerous stairwells in the building.
- The second floor of the centre was used as office space for administration staff.

On the most recent inspection the external grounds did not promote accessibility and were found not to be safe for residents. Inspectors found that work had been completed in this area and small external areas were created outside of the downstairs units for residents so they were safe and accessible. They also had garden furniture and flowers. This however, did not facilitate residents on the first floor to independently access the outdoors as some residents could not leave their unit without the support of staff.

The provider has responded by stating that this would be addressed by 2020 and that a local implementation group had been created to discharge residents over a five year period to community settings. Inspectors requested that this plan be submitted to the Chief Inspector to provide assurances of the measures which are to be implemented to support residents to successfully be discharged from the centre. Inspectors also determined that this plan needed to consider the internal transitions that would occur in the interim five years to ensure that the environment is used to its maximum potential as the number of residents residing in the centre decreases. This is due to be submitted by 31 August 2016.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Inspectors found that the arrangements in place for the effective management of health and safety and risk management remained inadequate. Although a number of actions had been completed the provider had failed to sufficiently improve the risk management systems within the centre.

The provider stated the following actions would occur to address these failings:

- Systems will be reviewed within the centre for the assessment, management and ongoing review of risk including a system for responding to emergencies.
- Risk assessment training has been provided to staff.
- A risk management committee has been established to ensure that the risk management systems are robust with the designated centre.

The timeframe provided was 31 of August 2016, therefore inspectors acknowledged that this timeframe had not been reached as of the day of inspection. However, inspectors reviewed the progress to date and found that the actions taken to date did not address the actual risk management systems of the centre. For example, an assessment had been conducted of the risks within the wider service; inspectors reviewed this document and found that the control measures failed to mitigate the risk present.

The risk of residents' slips/trips and falls had been identified. Control measures identified included the use of evidenced based tools to reduce the risk. However, inspectors found that this was not consistently occurring in practice. In other instances the risk was increased following the implementation of control measures. Therefore inspectors were not assured of the validity of the document in reflecting the actual level of risk in the centre or that the risk at the centre was decreasing. This document was also not specific to the centre.

A risk management group had been established as stated in the action plan from the March 2016 inspection. From a review of meeting minutes inspectors found the focus of the group was regarding the implementation of documents such as risks registers as opposed to reviewing the actual risk within the centre to ensure the service was safe and effective.

Some staff had been provided with risk management training in July 2016. Overall considering the findings of the previous inspection, inspectors determined that whilst the timeframe had yet to pass, insufficient progress had occurred in the interim.

A considerable risk was identified by inspectors in March 2016 due to the absence of suitable fire management systems. As a result, inspectors requested that the provider ensure a review of the building would be conducted by a competent person in fire safety. This occurred and the report was submitted to HIQA. The assessment identified that works were required to:

- Upgrade the sub compartments.
- Fire proof the ceiling levels.
- Install self closers.
- Install intumescent seals.

A meeting was held with HIQA on 5 May 2016, in which the provider confirmed that this work would be complete by the end of September 2016. The work was due to commence on 1 August 2016. However, on the day of inspection the work had yet to commence. Management were not clear of the rationale for this. HIQA was subsequently provided with information to state that there was a delay in the commencement of the work due to the tendering process; however the work would commence in September. At the time of writing this report, no completion date could be provided. Therefore the failing is repeated at the end of this report.

The inspectors found that whilst some actions relating to fire had been completed some remained outstanding. Inspectors found that the fire notices had not been upgraded and that the building layout and escape routes were not clearly displayed. The majority of staff had received refresher training in fire safety and fire drills had occurred. Inspectors

however were not assured of the effectiveness of this training. They observed fire doors with ineffective self closers to be left open, fire doors to be held open with furniture and bedrooms doors to be left open while residents were sleeping. While staff were able to tell inspectors of the actions to be taken in the event of a fire, the preventative measures were not implemented. Furthermore, residents had not been supported to be aware of the procedures to be followed in the event of a fire as they were not involved in any of the drills.

Overall, inspectors found the provider had not taken appropriate action in relation to health, safety and risk management. The action that had taken place was disproportionate considering that the risk was identified as major on the organization's risk register.

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:

The inspectors reviewed the actions from the most recent inspection and found that improvements were required in terms of safeguarding and supporting residents with behaviours that challenge.

The centre had policies and procedures in place for the prevention, detection and response to abuse. However, a repeated action in each inspection since October 2014 was that staff had not received training in the protection of vulnerable adults. Inspectors were provided with training records which demonstrated that this failing remained as of this inspection.

Staff on duty were able to inform inspectors of the appropriate action to be taken in the event of an allegation or suspicion of abuse. The provider had notified HIQA of allegations and suspicions of abuse following the last inspection. Inspectors reviewed the safeguarding documentation maintained in the centre and found that in the main

appropriate action was taken once an allegation or suspicion of abuse was reported to management. However, in one instance there was a delay in the reporting and inspectors found that the appropriate action had not been taken to ascertain the rationale for the delay to prevent a reoccurrence.

As identified on previous inspections the provider had not ensured all staff had received training in the management of behaviour that is challenging and de-escalation techniques. This was evidenced from a review of training records.

Inspectors found, on the last inspection, that personal intimate care plans did not effectively account for changes in need. Of the sample reviewed on this inspection, inspectors found that they had been reviewed.

In March 2016, inspectors were informed that a mechanical restrictive practice was no longer in use. However, the behaviour support plan had not been reviewed to support this information. On this inspection, the plan had been reviewed and daily records confirmed that the restrictive practice had not been utilized since the last inspection.

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

Findings:
The provider failed to ensure that all incidents had been notified to HIQA as required by the regulations.

From a review of residents' personal plans, inspectors found an incident in which a resident had sustained a laceration to the head. This had not been reported to the Chief Inspector within three working days as required by Regulation 31. This injury had occurred the week prior to the previous inspection. Therefore a review had not occurred to investigate the reason for the absence in reporting and if any other incidents or notifiable events had also not been reported. The inspectors were not assured that all incidents had been reported to the Chief Inspector.

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):

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

Findings:

Inspectors found that efforts had been made for some residents to access opportunities for skill development. However, there remained an absence of appropriate assessment to identify opportunities for residents to engage in training, education and employment.

Inspectors found that while there had been an increase in day trips for residents, personal plans did not demonstrate that an assessment had occurred of opportunities for residents to engage in education, training and employment and inspectors observed that the majority of residents' lives remained passive. Residents continued to have limited opportunities for meaningful engagement.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

From a review of personal plans it was evident that plans of care were created for residents following a nursing assessment. As the centre was nurse led, the plans of care were reviewed on a three monthly basis. Of the sample of plans reviewed, inspectors

confirmed that plans of care had been reviewed following the last inspection. Inspectors found that the health care plans adequately described the care to be provided to ensure residents' health care needs were met.

Residents had regular access to their general practitioner (GP) and residents were assessed by relevant Allied Health Professionals if a need arose. Multi disciplinary meetings were also held for residents.

Deficits had been identified in the monitoring of some residents' weight in March 2016. The provider responded by stating that all residents would be supported to have their weights monitored on a monthly basis or more frequently as required. However, inspectors found instances in which this was not occurring. There was no rationale recorded for this.

In March 2016, inspectors observed mealtimes in different areas and found inconsistent practices occurring. The provider responded by stating that a review would occur to ensure that meals would be served in a timely manner. Inspectors reviewed the record of this review and found that in a one hour period, three separate sittings for dinner had occurred in the one room. Therefore demonstrating that residents' meal times lasted approximately 20 minutes.

Of the mealtimes observed on this inspection, inspectors found inconsistent practices remained. For some residents mealtimes were a social experience however, for other residents, while they were supported to have their meals in line with their assessed needs, inspectors observed the mealtime to be task orientated with limited interaction.

Following on from the previous inspection the provider stated that residents would be involved in the preparation of their meals as far as is reasonably practicable and that a procurement card would be introduced to improve the opportunities for residents to purchase ingredients and cook their own meals. This was due to be implemented on the 31 July 2016. At the time of this inspection it had not occurred.

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:

The requirement to update the policies and procedures in place for the ordering, receipt, prescribing, storing, disposal and administration of medication had been identified on all previous inspections since October 2014. The provider had responded in the most recent action plan that this would occur by 31 August 2016. Therefore as the timeframe had not been reached, the action is repeated in the action plan at the end of this report. However management informed inspectors that it is in progress.

A risk of safe administration of medication had been identified in June 2015 and March 2016, as the prescription sheets were not always legible. Inspectors also noted that the times on medication records were in the twelve hour clock as opposed to the twenty four hour clock. The provider responded by stating a review would occur of the prescription and administration records would also take place. This was also due to be completed by 31 August 2016. Staff informed inspectors that they were aware that new templates were due to be implemented. Therefore the failing is repeated at the action plan at the end of the report. Furthermore, on this inspection inspectors identified that prescription sheets were two sided. As a result some medications had the same coding. Inspectors found that this resulted in it being unclear which medication had been administered at specific times, posing a risk to safe administration practices.

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:

The provider has failed to ensure that there are effective governance and management arrangements in place to ensure the service provided was appropriate to residents' needs, consistent and effectively monitored. The inspectors found the lack of effective governance arrangements resulted in a service that did not ensure positive outcomes for residents in particular relating to their social care needs.

As identified in this report, there had been some improvement in the practices within the centre. Following the findings in March 2016, the provider had conducted an unannounced visit. The unannounced visit conducted had identified deficits in practice. Inspectors acknowledged that some actions arising had been completed. For example, residents' meetings were not occurring and they had commenced as of this inspection. Improvement had also occurred to the decor. However, other key areas identified such as the implementation of medication audits, a review of the policies and procedures which were out of date and the implementation of unit specific risk registers were not complete. The dedicated time frame for these actions had passed.

There had also been audits completed and sub committees implemented. However, inspectors determined that the impact of these interventions had a negligible impact on the day to day lives of residents; residents continued to have passive days with an absence of meaningful activities. Inspectors found that audits primarily focused on quantitative information and failed to inform on residents' quality of life. For example, specific templates were completed as opposed to the effectiveness of the templates on the quality of service delivered. The inspectors reviewed an audit of care plans that had been conducted however, it did not identify if the resident was supported as per the plan of care. An audit had also been conducted on the activities that residents had taken part in. However, the meaningfulness of these activities had not been identified.

The review of the quality and safety of care included the views of residents and/or their representatives, who expressed satisfaction with the service delivered.

Fundamentally, inspectors found that there was an absence of accountability within the management structures. For example, the persons responsible for ensuring that actions required were implemented were not clear.

The provider had informed HIQA of the intention to reconfigure the management structure by the 1 September 2016. However, inspectors determined that in the interim, insufficient progress had occurred and limited focus was placed on the outcomes for residents and their experiences.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:
Leadership, Governance and Management

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

Findings:

The person in charge had been absent from the centre for more than 28 days as of the day of inspection. The Chief Inspector had not been notified as required by Regulation 32.

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:

This cumulative findings of this inspection demonstrate that there was an absence of appropriate assessments, limited supports were available for residents' social care needs to be met and practices which were led by routine as opposed to the individual wants and needs of residents. Therefore inspectors were not assured that the number, qualifications and skill mix of staff were appropriate to the number and assessed needs of the residents and the size and layout of the centre.

This has been a continued failing on all three previous inspections of the centre. Inspectors found during each inspection that the number, qualifications and skill mix of staff were not evidenced to be appropriate. The provider had stated that a framework had been identified and would be implemented by the end of July 2016. Management informed inspectors at the commencement of the inspection that this had commenced in other areas of the wider organisation however it had not commenced in this centre. Furthermore, the provider stated that staffing levels would be allocated based on the needs of the residents' personal plans. However, inspectors found that personal plans did not adequately identify the supports residents required therefore it was not clear how this would be achieved.

On this inspection, inspectors found that the failing remained as:

- Resources remained allocated to the centre based on funding and historical patterns as opposed to the needs of the residents.
- Inspectors observed that residents' day was determined by a standard routine as opposed to individual need.

- Inspectors observed staff to supervise residents for large parts of the day with limited interaction as opposed to actively support residents to engage in activities in line with their interests and capabilities.

Furthermore, staff training had also been identified as a failing on each inspection since October 2014. Deficits remained as of this inspection. Not all staff had received training in manual handling, positive behaviour support or safeguarding. Inspectors also determined that staff required additional training to ensure that they could support residents in areas such as person centred planning, dementia and active ageing. The provider had responded by stating that a system would be developed by the end of July 2016, which would involve individual training cards to monitor mandatory training. Staff informed inspectors that this had commenced and that it was their responsibility to identify dates to complete the training based on a training schedule. However, inspectors found that there was an absence of oversight from management of the training needs of staff to identify the training to be provided.

Judgment:
Non Compliant - Major

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:

Jillian Connolly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Glenbow
Centre ID:	OSV-0003364
Date of Inspection:	02 August 2016
Date of response:	12 September 2016

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:

Residents' daily life was led by routine as opposed to individual choice and control. Inspectors found that activities such as meal times and bed time was determined by this routine and residents spent large portions of their day in a day room.

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

1. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

- A full review of all Persons Centred Plans are been completed for all residents. The purpose of this review is to identify the real needs and preferences for each individual within the service. The result of this review will now inform staff on how to facilitate and provide more choice and control for the resident.

Person Responsible: Person in Charge.

Proposed Timescale: 16th September 2016.

- The residents with their key worker are being encouraged to look at their day in a very different way that best reflects their needs, goals and the activities that will provide them with real choice. Residents are being offered a variety of opportunities. A number of community based activities have been identified according to residents' wishes. Local organisations contacted include family resource centres, Active Retirement groups, local library, gardening centre and local community centre. Residents are participating in a number of taster sessions over a six week period to identify their individual preference. This six week period commences on the 12th September and concludes on the 24th October 2016. Individual outcomes are been documented and this information is to be the basis for formulating goals for participation into community life.

Person Responsible: Person in Charge

Proposed Timescale: 24th October 2016

- Social role valorisation training has been arranged for 13th and 14th September 2016 through the Leap organisation. This ethos of this training is to explore with staff how best to support our residents to lead "A good life". Staff have been identified to do this training and further dates have been requested.

Person Responsible: Person in Charge

Proposed Timescale: 14th September 2016

- An additional separate dining room has been identified to enable each resident to enjoy mealtimes at their own leisure, and will be in operation from 19th September 2016

Person Responsible: Person in Charge

Proposed Timescale: 19th September 2016

- Alternative food options continue to be discussed at residents' house meetings on a weekly basis. Residents are facilitated to do their shopping within the local community, to exercise and experience personal independence and choice in their daily lives. A representative has been identified from each residential area to take responsibility for ensuring that residents participate in food shopping. This commenced on 6th September 2016.

Person Responsible: Person in Charge

Proposed Timescale: 6th September 2016

- Involvement in food preparation is incorporated into Person Centred Plans and times are been allocated in residents' daily lives to support each person in the preparation of light meals and snacks.

Person Responsible: Person in Charge.

Proposed Timescale: 24th October 2016

- Residents no longer sleep in communal areas, since 3rd August 2016. If residents require to rest during the day it is facilitated within their own personal bedroom. The persons individual care plans identify each person's needs

Person Responsible: Person in Charge

Proposed Timescale: 3rd August 2016

- All bedrooms are being painted in residents' chosen colours. Each bedroom has been personalised according to residents' likes and preferences. This schedule of works will be completed by 30th September

Person Responsible: Person in Charge

Proposed Timescale: 30th September 2016

- All bedroom doors are closed throughout the day and night to maximise privacy. A memo has been distributed to all staff to remind them that the person's privacy and dignity must be respected in regards to the closing of doors. Daily checks are in place to ensure privacy is been maintained.

Person Responsible: Person in Charge

Proposed Timescale: 9th September 2016

- Reassignment of staff has commenced to facilitate residents to stay in their own sitting room before they retire to bed at a time of their choosing.

Person Responsible: Person in Charge

Proposed Timescale: 16th September 2106.

Proposed Timescale: 24/10/2016

Theme: Individualised Supports and Care

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

Practices observed by inspectors were not indicative of promoting the privacy and dignity of residents. This included the use of language and sleeping arrangements for residents.

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:

- All bedrooms are being painted in residents' chosen colours. As of today 50% of all bedrooms are painted. The remaining bedrooms are to be completed by 30th

September.

Person Responsible: Person in Charge

Proposed Timescale: 30th September 2016

- All bedroom doors are closed throughout the day and night to maximise privacy. Memos have been distributed to all staff to inform them that bedroom doors are to be closed at all times unless it is contrary to residents own wishes.

Person Responsible: Person in Charge

Proposed Timescale: 9th September 2016

- A Communication Strategy workshop commenced on September 5th and further workshops are scheduled for 12th & 19th September, and 3rd October 2016, to include all staff. These workshops are being facilitated by the Speech and Language Therapist to explore cultural language and attitudes with the purpose of promoting a different style of communication and engagement with the residents.
- To date 12 staff have participated in these workshops with a further 30 staff identified for the remaining workshop.

Person Responsible: Person in Charge

Proposed Timescale: 3rd October 2016

- Disability Awareness training is scheduled to take place week commencing 3rd October 2016 to heighten awareness of staff on the matters that support residents' dignity in their everyday life.

Person Responsible: Person in Charge

Proposed Timescale: 10th October 2016

Proposed Timescale: 10/10/2016

Theme: Individualised Supports and Care

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

Residents were not supported to manage their finances.

3. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

- Residents are supported to manage their monies in their own home by staff. They are further supported to access their monies Monday to Friday by Clerical staff in our financial office.

Person Responsible: Person in Charge

Proposed Timescale: 7th September 2016

- A person has been appointed from the Service Administration team to provide information to the residents and their supporting staff on their personal financial affairs.

This information sharing process will be completed by the 16th of September 2016.

Person Responsible: Person in Charge

Proposed Timescale: 16th September 2016

- A new financial competency assessment has been drafted to identify the socialisation allowance required for each resident.
- Each resident will, through consultation regarding their ability to give consent, be provided an option of their own individual bank accounts. This matter will be explored further with the assistance of an external advocate.
- To ensure that each resident's financial affairs are managed appropriately the HSE best practice and associated financial regulations will continue to be employed until the individual banking option process is concluded.

Person Responsible: Provider/ Person in Charge

Proposed Timescale: 31st December 2016

Proposed Timescale: 07/03/2017

Theme: Individualised Supports and Care

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

Records did not support that the activities residents' partook in were line with their interests and capabilities.

4. Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

- A full review of all Persons Centred Plans is in process and will be completed for all residents by 16th September. As of the 8th of September 52% of these reviews are completed and the remaining 48% will be completed by the 16th of September. The purpose of this review is to identify the real needs and preferences for each individual within the service. The result of this review will now inform staff on how to facilitate and provide more choice and control for the resident.

Person Responsible: Person in Charge.

Proposed Timescale: 16th September 2016.

- Social role valorisation training has been arranged for 13th and 14th September 2016. This ethos of this training is to explore with staff how best to support our residents to lead "A good life". Staff have been identified to do this training and further dates will be identified for October, November and December with an outside organisation so that the service can maximise the number of staff receiving this training.

Person Responsible: Person in Charge.

Proposed Timescale: 14th September 2016

• A number of community based activities have been identified according to residents' wishes. Local organisations contacted include family resource centres, Active Retirement groups, local library, gardening centre and local community centre. Residents are being offered a number of opportunities "taster sessions" over a six week period to identify what areas they would like to explore further. This six week period commences on the 12th September and concludes on the 24th October 2016. Individual outcomes will be documented as a result of the six week "taster sessions" and this information will form the basis for goal setting to support the residents present and participation in their local community.
Person Responsible: Person in Charge.
Proposed Timescale: 24th October 2016

Proposed Timescale: 24/10/2016

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

Theme: Individualised Supports and Care

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

For the majority of residents, their time was primarily spent within the centre or in the day service on the campus.

5. Action Required:

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

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

• Resources have been identified and allocated to enable and facilitate residents to be present in their local community. This will be done through shopping in the local supermarket, attending religious facilities based on personal choice, engaging in local community activities

Person Responsible: Person in Charge.

Proposed Timescale: 19th September 2016.

• A better understanding of meaningful presence and participation for each resident will emerge after the six week "taster sessions" process of what supports will be required to develop and maintain relationships and links with the wider community. A number of community based activities have been identified according to residents' wishes and residents are sampling same for a period of 6 weeks, to commence on 12th September 2016.

Person Responsible: Person in Charge.

Proposed Timescale: 24th October 2016.

Proposed Timescale: 24/10/2016

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:

Inspectors identified an instance in which a personal plan had not been reviewed following a change in need.

6. Action Required:

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

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

- The identified instance as referenced Under Regulation 05 (6) has been addressed and the personal plan has been reviewed and updated accordingly.

Person Responsible: Person in Charge.

Proposed Timescale: 7th September 2016.

- All personal plans have an agreed scheduled quarterly review evaluation identified or sooner as required based on any changing needs of the residents.

Person Responsible: Person in Charge.

Proposed Timescale: 16th September 2016 and on-going thereafter.

Proposed Timescale: 16/09/2016

Theme: Effective Services

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

Residents were supported and subsequently charged in line with the inpatient charges for 24 hour nursing care. These arrangements were not supported by residents' assessments.

7. 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:

All full assessment of each resident's social support needs through "A Key To Me", person centred planning tool, is now utilised fully across the service. This process is informing the personal expenses each individual are requiring to experience opportunities in their communities. This is informing, and will determine the level of payment the person will contribute under the "long stay charge regulation". The socialisation allowance within this financial regulation will be fully applied to each resident.

Person Responsible: Person in Charge.

Proposed Timescale: The commencement of the socialisation allowance component of the long stay charge assessment begins 12/9/2016.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

Personal plans did not outline the supports residents' required to maximise their personal development.

8. Action Required:

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

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

- All residents are in the process of developing a meaningful personal plan. All of these plans will reflect each resident's wishes and preferences and identify and outline the services and supports necessary for each person to achieve a good quality of life. These plans will be closely monitored through a keyworker system.

Person Responsible: Person in Charge

Proposed Timescale: 16th September - 24th October 2016

Proposed Timescale: 24/10/2016

Theme: Effective Services

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

In some instances, key workers identified goals for residents. The rationale for why that goal was identified was based on their knowledge of the resident. This was not supported by a robust assessment.

9. Action Required:

Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

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

- A total review of all person centred plans using "A Key To Me" is underway. These plans are capturing residents "Lived Experiences" and outline the goals for each person, and the services and supports each person needs to reach/ achieve their goals. Training for staff on the importance of a meaningful person centred plan is underway and proactively monitored.

Person Responsible: Person in Charge

Proposed Timescale: 16th September 2016 (first review completed) and quarterly thereafter.

Proposed Timescale: 16/09/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The premises were not fit for purpose.

10. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

- The residents within the current service are part of a decongregation planning process. The Living a Different Way community living project has been identified and submitted to the Authority as of the 30th of August 2016.

Person Responsible: Provider.

Proposed Timescale: 31st December 2020

- In order to support residents in the intervening period certain refurbishments are taking place within the existing centre to enhance the residents living environment. A schedule of work has commenced since the 5th of September 2016 to incorporate decoration and refurbishment work necessary to make the living areas more home like and accessible. This work will also include necessary firework.

Person Responsible: Person in Charge / Provider

Proposed Timescale: 30th November 2016

- Bedrooms that are located near the main entrance are been reviewed with a view to increasing the privacy for the residents. PIC forwarded a request to the Estates Manager to obtain assistance in resolving this matter. Plans are currently being drawn up by the appropriate personnel in HSE Estates to address this matter.

- Remedial works, including a suitable partition, and clear direction and signage for visitors, is been carried out to ensure that all residents have the privacy and dignity they require.

Person Responsible: Person in Charge / Provider

Proposed Timescale: 30th November 2016

- Toilet cubicles to be upgraded to ensure floor to ceiling partition between each cubicle.

Person Responsible: Person in Charge

Proposed Timescale: 30th November 2016

Proposed Timescale: 30/11/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The systems in place to assess and effectively manage risk were inadequate.

11. 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:

- Local HSE Quality & Risk Manager is facilitating a total review of the risk register and risk management systems in the centre on Wednesday 7th September 2016

Person Responsible: Person in Charge.

Proposed Timescale: 19th September 2016

- Briefing session to be facilitated by local HSE Quality & Risk Manager to put in place an effective risk management system to record, manage and review ongoing risk

Person Responsible: Person in Charge.

Proposed Timescale: 19th September 2016

Proposed Timescale: 19/09/2016

Theme: Effective Services

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

The management systems in place to safeguard against fire were inadequate.

12. Action Required:

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

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

- Routine weekly checklist on fire safety to be put in place for each floor level of the campus and other residential on site, and completed end of each month

Person Responsible: Person in Charge.

Proposed Timescale: 30th September 2016

- Fire action notices to be updated to indicate exact actions in the event of fire and placed in prominent areas around the building

Person Responsible: Person in Charge / Provider

Proposed Timescale: 16th September 2016

- Fire Risk Assessment has been completed by Fire Safety Consultant on the Main Campus Building. The Fire Consultant prepared a Tender package for rectification of

deficiencies noted. A Contractor has been appointed and the upgrade works is to begin on 20th September 2016. These works include upgrading sub compartments, fireproof to ceiling level, installation of self closers and installation of intumescent seals

Person Responsible: Person in Charge / Provider

Proposed Timescale: 30th November 2016

- Fire Register are be updated to reflect the requirements outlined by the Fire Safety Consultant.

Person Responsible: Person in Charge.

Proposed Timescale: 30th September 2016

- Inspection of all site fire doors to be undertaken.

Person Responsible: Person in Charge / Provider

Proposed Timescale: 30th November 2016

- Monthly inspections of Fire Fighting equipment

- Person Responsible: Person in Charge

Proposed Timescale: 30th September 2016

- Local Fire Policy are been updated

Person Responsible: Person in Charge.

Proposed Timescale: 19th September 2016

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

Preventative measures such as self closers in pertinent areas and intumescent seals were ineffective.

13. Action Required:

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

- Fire Risk Assessment has been completed by Fire Safety Consultant on the Main Campus Building. The Fire Consultant prepared a Tender package for rectification of deficiencies noted. A Contractor has been appointed and the upgrade works is to begin on 20th September 2016. These works include upgrading sub compartments, fireproof to ceiling level, installation of self closers and installation of intumescent seals

Person Responsible: Person in Charge / Provider

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

Residents were not supported to be aware of the procedures to be followed in the event of a fire.

14. Action Required:

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

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

- A review of PEEPs has commenced to reflect each resident's cognitive ability to understand the evacuation process. A traffic light system is to be incorporated into each PEEP plan which will indicate to staff the level of support needed by each resident to ensure effective and safe evacuation from the building.

Person Responsible: Person in Charge

Proposed Timescale: 19/09/2016

Theme: Effective Services

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

The evacuation procedures displayed in the designated centre were not clear.

15. Action Required:

Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

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

- New accessible evacuation procedures are to be displayed prominently to ensure all staff, visitors and residents are aware of the procedures to be followed in the event of fire.

Person Responsible: Person in Charge

Proposed Timescale: 30/09/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all staff had received training in the management of behaviour that is challenging and de-escalation techniques.

16. 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:

- Training dates have been scheduled for management of behaviours that challenges for the remainder of the year. Next training date is 14th September
- Additional training dates have also been requested and confirmed to ensure relevant staff receives training on the management of behaviours of concern and de-escalation techniques. A schedule will be agreed no later than the 19th of September to provide on-going training up to the end of the year.

Person Responsible: Person in Charge

Proposed Timescale: 31/12/2016

Theme: Safe Services

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

Not all staff had received up-to-date training in the protection of vulnerable adults.

17. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

- Additional training around protection of vulnerable adults has been requested from the safeguarding team. Training to commence 12th September 2016, with additional dates provided in November 2016.

Person Responsible: Person in Charge

Proposed Timescale: 30th November 2016

- As of August 2016 a Social Worker has been assigned to the residential service to support front line staff and the management team to address any potential safeguarding concerns, to review any new risks that could impact on the development of a safeguard concern, to discuss with staff on the ground the importance of transparent and accountable practices and be fully aware of local and national policy in this area. The expected impact of this new appointment is to enhance the lives for people who are vulnerable in a meaningful way.

Person Responsible: Person in Charge

Proposed Timescale: Ongoing with a review of the impact of this intervention by year end.

Proposed Timescale: 30/11/2016

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 Chief Inspector had not been notified of an injury sustained by a resident resulting in a laceration to the head.

18. 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:

- NFO6 submitted retrospectively in relation to the incident identified.
- Going forward a record of all incident occurring are be submitted to the chief inspector within timeframes. This mandatory practice will be monitored weekly.

Person Responsible: Person in Charge

Proposed Timescale: 5th September 2016 and on-going.

Proposed Timescale: 05/09/2016

Outcome 10. General Welfare and Development

Theme: Health and Development

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

There was an absence of assessment to identify opportunities for residents to engage in education, training and employment.

19. Action Required:

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

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

- A number of community based activities have been identified according to residents' wishes. Local organisations contacted include family resource centres, Active Retirement groups, local library, gardening centre and local community centre. Residents are to have a number of taster sessions over a six week period to identify their individual preference. This six week period commences on the 12th September and concludes on the 24th October 2016. Individual outcomes are to be documented and this information will be the basis for formulating goals for participation in community life and/ or further training

Person Responsible: Person in Charge

Proposed Timescale: 24/10/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Residents were not supported to have their weight monitored in line with their personal plans.

20. Action Required:

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

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

All residents weight are be recorded monthly or weekly when required as per their care plan and documented in the appropriate section of their individual plans.

Person Responsible: Person in Charge

Proposed Timescale: 05/09/2016

Theme: Health and Development

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

Residents did not have the opportunity to be involved in the preparation of their meals.

21. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

- Involvement in food preparation is to be incorporated into Person Centred Plans and times are to be allocated in residents' daily lives to support them to participate in the preparation of light meals and snacks

Person Responsible: Person in Charge

Proposed Timescale: 24th October 2016 to complete for all residents.

Proposed Timescale: 24/10/2016

Theme: Health and Development

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

Inspectors observed inconsistent practices at meal times. Furthermore records demonstrated that there were three sittings of a meal within one hour.

22. Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

- An additional separate dining room has been identified which will facilitate social interaction and provide sufficient time for each resident to enjoy mealtimes at their own leisure. This will come into effect from 19th September 2016.

Person Responsible: Person in Charge

Proposed Timescale: 19th September 2016

- Communication strategy workshops are commencing on September 5th and on September 12th & 19th September to include all units. These are to be facilitated by the Speech and Language Therapist and are to explore cultural language and attitudes and assist in promoting the dignity of residents.

Person Responsible: Person in Charge

Proposed Timescale: 19th September 2016

Proposed Timescale: 19/09/2016

Outcome 12. Medication Management

Theme: Health and Development

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

The practices of the centre were not guided by appropriate centre specific policies and procedures. A review was also required of the prescription and administration records to ensure that they are legible and appropriately coded to reduce the risk of medication errors.

23. Action Required:

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

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

- A centre specific policy is currently being developed to reflect the appropriate medication management in line with best practice.
- All medication kardex are to be in twenty four hour clock and medication kardex are being re-designed to avoid double sided prescription

Person Responsible: Person in Charge

Proposed Timescale: 15th October 2016

- A review of prescription and administration records will take place with pharmacy service to ensure prescriptions are legible

Person Responsible: Person in Charge
Proposed Timescale: 31st October 2016

Proposed Timescale: 31/10/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The management systems in place did not promote a safe and effective service or one that ensured positive outcomes for residents.

24. Action Required:

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

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

- An Acting Director of Service has been appointed since the 1st of August with a very clear remit to provide the leadership and management skills and competencies necessary to address the governance deficit within the service.

- The full time Director of Service post is approved and is currently with the HSE National Recruitment Services.

Person Responsible: General Manager/Provider Nominee

Proposed Timescale: Recruitment and Selection Campaign process underway - 3 months from the time of advertisement : 31st January 2017.

- There is now in situ a clearly defined management structure which will identify the line of authority and accountability in the centre.

- Three PICs have been appointed, are to submit relevant paperwork and are to manage the designated centre and ensure the effective governance, i.e. the implementation of audits, policies and procedures review and the implementation of unit specific risk registers

Person Responsible: Person in Charge

Proposed Timescale: 30th September 2016

- A review will be undertaken of all audits, to gather qualitative information and to establish their effectiveness in ensuring quality of life for residents

Person Responsible: Person in Charge

Proposed Timescale: 30th November 2016

Proposed Timescale: 31/01/2017

Theme: Leadership, Governance and Management

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

The management systems did not identify the individuals with accountability for addressing deficits in service delivery.

25. Action Required:

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

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

- There will be a clear defined management structure which will identify the line of authority and accountability within the centre. A/ Director of Services has been appointed.
- Three PICs have been appointed, are to submit relevant paperwork and are to manage the designated centre and ensure the effective governance, ie the implementation of medication audits, policies and procedures review and the implementation of unit specific risk registers

Person Responsible: Person in Charge

Proposed Timescale: 30/09/2016

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

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

The person in charge had been absent from the centre for more than 28 days as of the day of inspection. The Chief Inspector had not been notified as required by Regulation 32.

26. Action Required:

Under Regulation 32 (3) you are required to: Provide notice in writing to the Chief Inspector where the person in charge is absent as a result of an emergency or unanticipated event, as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more, specifying (a) the length or expected length of the absence and (b) the expected dates of departure and return.

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

- NF20 has been submitted in respect of Absence of PIC and there is a now full time person in charge in the designated centre

Person Responsible: Person in Charge

Proposed Timescale: 05/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Inspectors were not assured that the number, qualifications and skill set of staff were appropriate to meet the needs of residents.

27. 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:

- Rosters are reviewed on a daily basis
- Staffing is assigned to each service area in accordance with the identified needs of the residents to support them to achieve a meaningful life experience.

Person Responsible: Person in Charge

Proposed Timescale: 5th September 2016 Complete

- Baseline assessments have yet to commence using HURST workforce planning framework. This process will roll out no later than the 31st of October 2016 to develop a system of assessing staffing levels to meet the assessed need of residents

Person Responsible: Provider

Proposed Timescale: 31st December 2016

Proposed Timescale: 31/12/2016

Theme: Responsive Workforce

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

Staff were not provided with the appropriate training.

28. 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 training needs analysis has been undertaken

Training prioritised and currently being delivered in September 2016:

- Communication strategy
- PCP training
- Fusing the Horizons (Dementia. Training)
- Management of behaviours that challenge

Person Responsible: Provider

Proposed Timescale: commencing week of 12th September on-going until 31st

December 2016

- Training dates have been scheduled for management of behaviours that challenge for the remainder of the year. Next training date is scheduled for 14th September

Person Responsible: Person in Charge

Proposed Timescale: 14th September 2016

- Additional training around protection of vulnerable adults has been requested from the safeguarding team. Training to commence 12th September 2016, with additional dates provided through full schedule for remainder of 2016

Person Responsible: Person in Charge

Proposed Timescale: 31st December 2016

- Communication strategy workshops are commencing on September 5th/ 12th/19th and the 3rd October to include all service areas. These are to be facilitated by the Speech and Language Therapist and are to explore cultural language and attitudes and assist in promoting the dignity of residents

- Person Responsible: Person in Charge

Proposed Timescale: 3rd October 2016

- Disability Awareness training will also take place week commencing 3rd October 2016 to address the dignity, rights and privacy of residents

Person Responsible: Person in Charge

Proposed Timescale: 3rd October 2016

- Social role valorisation training arranged for 13th and 14th September 2016. This training will cover topics including developing the PCP process

Person Responsible: Person in Charge

Proposed Timescale: 14th September 2016

Proposed Timescale: 31/12/2016