STEWARTS CARE
ANNUAL REVIEW OF QUALITY AND SAFETY OF CARE AND SUPPORT

Designated Centres 1 - 29

PUBLISHED APRIL 2019
STEWARTS CARE

Designated Centre 1

Location:	Palmerstown Square, Palmerston Heights, Min A Cree, Red Cow Cottages
PIC:	Elaine Coffey
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

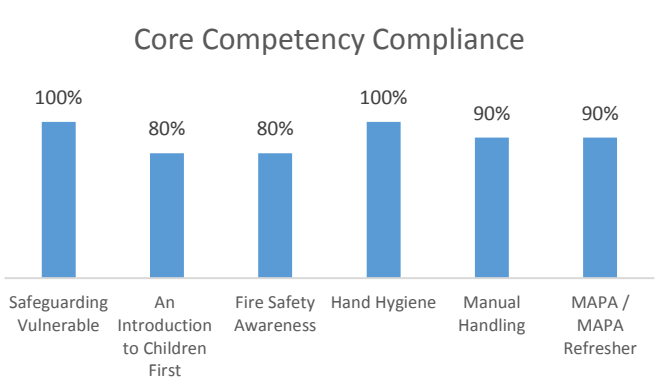
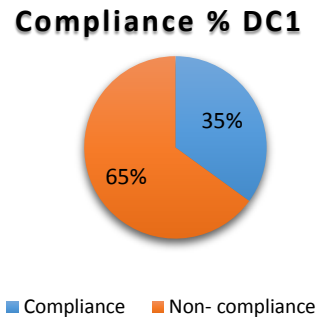
- Don't like when agency staff work in the house
- Would be nice to have a back garden
- I would like the Coach house hours to be extended
- Would like the wall between the kitchen and dining room knocked down.
- Would like to go out on drives more often.
- My home looks like an office not enough room on the table because of office work
- I have no privacy
- I am unhappy as I always have 1:1 staff
- Would like to change my day service
- I would like a new bed

Friends and Family Survey Feedback 2018

- Care staff are excellent and very welcoming.
- Unless I contact Stewarts I am never contacted at all
- (Family members) carers were changed at the end of last year and I was not updated.
- I never have a key member of staff that I can contact in regards general information about (family member)
- Feel there is a delay in dealing with issues e.g. psych health, had a consult in May 2018 still waiting for follow up action plan.
- There is a general disconnect between the house and day services.
- Important decisions are made and we are either not included beforehand or not informed at all.
- Keyworker moved and we were not informed who new keyworker is.
- Concerned our family member's capacity to understand is not being recognised.
- Management listen but do not communicate back to us as a follow up.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	There is a statement of purpose in folder 1 in each home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in each house.	Ensure all staff sign each policy to say they have read them. As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is a vacancy in this designated centre of 1 WTE.	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Palmerstown Height** **Shift allocation as per 2019 DNA;** 1 sleepover shift each day **Palmerstown Square** **Shift allocation as per 2019 DNA;** 1 sleepover staff each day **Min A Cree** **Shift allocation as per 2019 DNA;** 1 sleepover shift each day **Red Cow Cottages** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking 1 HCA Day 8-8pm 1 RN 8-11am, 4pm- 8pm (Mon- Fri) 1 RN 8-8.15pm (Sat + Sun)	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review. In one home the person due to be on shift according to the roster and the person who was on shift were different. The staff could not explain this.	Work needs to be completed to ensure printed rosters match what is on the system.
Regulation 16: **Training & Development**	**Findings**	

Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff complete and keep up to date with core competency training and refresher courses.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	

Ensuring staff meetings take place monthly	Staff meetings were taking place monthly and minutes were well documented.	
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Majority of notifiable incidents were notified within the correct timeframes.	Ensure all notifiable incidents are sent to HIQA within the required timeframe.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and recent complaints have been logged and have been processed correctly as per organisational policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have a personal support plan that is available to them or their representatives.	Ensure personal plans are updated annually.
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	Not evident that all service users had an OK Health Check in 2018 but all have had an OK Health Check in the past 12 months.	Ensure all service users receive an OK Health in 2019 reviewed by a nurse to ensure appropriate clinical oversight.
Ensure each resident has had an Annual Medical Review completed by a GP.	2 service users have no evidence on SURA of receiving an AMR in 2018.	Ensure all service users receive an AMR in 2019, documented in the correct place on SURA.
Ensure there is care plans in place for each identified need.	Some work required in this area. PIC to ensure that all staff follow the agreed pathway for creating Health care plans.	Discrepancies exist between summary section of OK health Check, Initial Indicators, Care Plans. Not all medical issues identified in the summary section of the OK Health Check follow through in the indicators and then through for development of care plans.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**

Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	**Palmerstown Sq** Has an up to date behaviour report **Min A Cree** One service user is being assessed by Psychology at present One service user has had no PBSP written in 2015 **Red Cow Cottages** One service user being assessed by Psychology Two service users had a review of their PBSP completed in 2018 by Psychology **Palmerstown Height** One service user has a dementia report completed by Psychology	Follow up on requests for behaviour support plans to be completed.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A No restrictions in this Designated Centre	
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	

All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	Majority of safeguarding plans in this designated centre are from Day Services	Ensure all safeguarding plans from Palmerstown Heights are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training	Staff are up to date with safeguarding training	Ensure all staff complete children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have had monthly keyworker meetings. Weekly service user meetings are taking place.	Ensure all residents get monthly keyworker meetings throughout 2019.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy, these need to be updated to ensure they highlight the needs of each service user in relation to advocacy.	Ensure advocacy initial indicators are updated annually as some have not been updated in the past 12 months. Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication initial indicators that detail the level of support needed when communication. This is reviewed annually.	Ensure communication initial indicators are updated annually as some have not been updated in the past 12 months.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without	Visitors are welcome in all homes at any time. Staff will provide a space for service users to meet privately with visitors if they require.	

restrictions and are given space and privacy to do so		
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All service user have access to their own possessions at all times. Linen is laundered by staff and returned to service users.	
Each resident is supported to manage their own financial affairs.	3 residents have their own bank accounts and manage their own money supported by staff. 1 service user manages his own finances with his own bank account and bank card. All other residents are supported financially by staff.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents in all homes are treated with dignity and respect by all staff	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	In all homes in this designated centre service users go to day services during the week. Residents take part in social outings on the weekends,	
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	All homes in this designated centre were clean and in good structural repair with minor issues identified through the monthly environmental audit. All issues have been LANDesked and are being followed up by the PIC.	

Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Staff cook all meals in this designated centre which allows service users to be involved in the planning and cooking of meals. It also allows service users to change their mind on what food they would like to eat.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**

Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is currently no planned transitions in this designated centre.	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management	Ensure all risk assessments are updated to the new format.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily checks are completed.	A number of staff require fire safety training and on site fire drill training

Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		Ensure all self-administration medication assessments are reviewed every 12 months
There is up to date PRN protocols in place.	All PRNs had protocols in place	
SAMs trained staff have in date SAMs training,	All SAMs trained staff had in date SAMs training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure all staff sign each policy to say they have read them.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Work needs to be completed to ensure printed rosters match what is on the system.
6	Ensure all staff complete and keep up to date with core competency training and refresher courses.
7	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
8	Each service users SURA documents should be reviewed annually (or sooner if required).
9	Ensure all notifiable incidents are sent to HIQA within the required timeframe.
10	Ensure personal plans are updated annually.

11	Ensure all service users receive an OK Health in 2019 reviewed by a nurse to ensure appropriate clinical oversight.
12	Ensure all service users receive an AMR in 2019,
13	PIC to ensure that all staff follow the agreed pathway for creating Health care plans.
14	Follow up on requests for behaviour support plans to be completed.
15	Ensure all safeguarding plans from Palmerstown Heights are reviewed within the correct timeframes.
16	Ensure all staff complete children's first training
17	Ensure all residents get monthly keyworker meetings throughout 2019.
18	Ensure advocacy initial indicators are updated annually as some have not been updated in the past 12 months.
19	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
20	Ensure communication initial indicators are updated annually as some have not been updated in the past 12 months.
21	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
22	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
23	Ensure all risk assessments are update to the new format.
24	Ensure all actions identified by the IPC Nurse are followed up with.
25	A number of staff require fire safety training and on site fire drill training
26	Ensure all self-administration medication assessments are reviewed every 12 months
27	Address service user issues that have arisen from survey.
28	Address family and friends issues that have arisen from survey.

Designated Centre 2

Location:	Gleneaston Drive, Gleneaston Ave, Gleneaston Court
PIC:	Deirdre Murphy
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

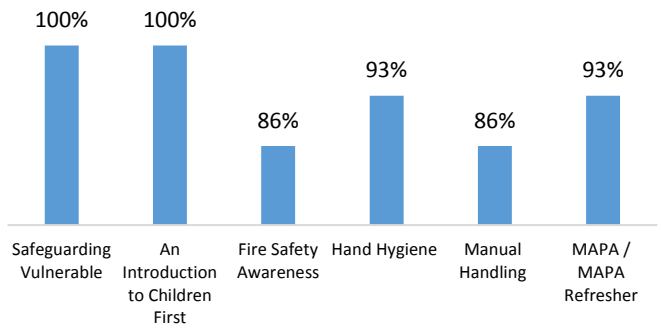
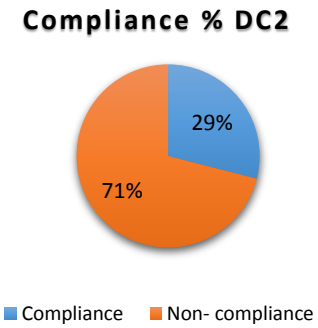
- I would like the garage turned into a sitting room so I can speak with visitors in private.
- I would like more pictures of my family and friends on my bedroom wall.
- Would like more space in my home
- I don't like unfamiliar staff
- I would like new curtains for my bedroom and I would like it to be painted blue
- I would like to go out more- coffee with my friends, Liffey vally and the cinema
- Not able to go to Yoga classes because staff was moved and now there's 1 staff and 5 service users.
- Bus in the morning is sometimes too early I am not able to have my breakfast with ease.
- Don't like service users on the Kilcoon bus getting too close and invading my privacy.
- Would like house to be painted.
- Get anxious when staff are not regular staff

Friends and Family Survey Feedback 2018

- (Family member) is well cared for.
- Carers are exceptionally caring.
- In general my daughter is very happy with staff and service users in her accommodation.
- Overall very pleased with the service.
- More staff could improve the service.
- I am not happy when agency staff are looking after (family member)
- Payments received when (family member) comes home stopped with no explanation or contact, very annoyed over this.
- At times (family member) cannot attend pre-arranged social occasions due to a lack of staff

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	The most up to date statement of purpose was not available in each home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in each house.	Ensure all staff sign each policy to say they have read them. As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	1 HCA vacancy in this designated centre	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Gleneaston Drive** **Shift allocation as per 2019 DNA;** 1 HCA sleepover 1 5-9pm Mon-Fri, 10-7.30 Sat, Sun **Gleneaston Court** **Shift allocation as per 2019 DNA;** 1 sleepover fluctuates between HCA and R/N; 1 HCA 5pm- 9pm Mon-Fri **Gleneaston Ave** **Shift allocation as per 2019 DNA;** 1 sleepover each night , 1 HCA 4-8 Mon-Fri, 1 R/N 8-12 Mon-Fri, 1 HCA 10-7.30pm Sat & Sun	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	The roster available in some homes did not always state the full complement of staff on duty, however it was confirmed that the workforce planning system did have the right information. Work needs to be completed to ensure printed rosters match what is on the system.
Regulation 16: **Training & Development**	**Findings**	

Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff complete and keep up to date with core competency training and refresher courses.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**

Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly in each home throughout 2018.	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most notifiable incidents were sent to HIQA within the correct timeframes.	Ensure all HIQA notifications are sent to HIQA within the correct timeframes.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and recent complaints have been logged and have been processed correctly as per organisational policy.	Complaints needs to be discussed at service user weekly meetings so all service users are aware of how to make a complaint.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have a personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check in the past 12 months.	Ensure all service users receive an OK Health Check in 2019 reviewed by a nurse to ensure appropriate clinical oversight.
Ensure each resident has had an Annual Medical Review completed by a GP.	1 service users have no evidence on SURA of receiving an AMR in 2018.	Ensure all service users receive an AMR in 2019, documented in the correct place on SURA.
Ensure there is care plans in place for each identified need.	Some work required in this area. PIC to ensure that all staff follow the agreed pathway for creating Health care plans.	Ensure all health issues identified in the brief summary of issues section are documented in the red initial indicators. Ensure red initial indicators state when there is a care plan in place. Ensure all chronic and acute conditions have a care plan in place. All needs sheets need to be deleted as they're no longer used in the service

Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	**Gleneaston Court** 2 service users had PBSP completed by previous CNS in behaviour in 2017 and are now waiting for review from Psychology 1 service user has had a PBSP completed by Psychology in 2019 **Gleneaston Ave** 1 service user has an up to date PBSP 1 service user has been referred to Psychology	Follow up on requests for behaviour support plans to be reviewed.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A No restrictions in this Designated Centre	
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	**Gleneaston Court** Safeguarding plans due for review **Gleneaston Ave** Safeguarding plans due for review	Ensure all safeguarding plans are reviewed within the correct timeframes.

All staff must receive safeguarding and Children's First Training	Staff are up to date with safeguarding and children's first training	
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have had monthly keyworker meetings. Weekly service user meetings are taking place.	Ensure all residents get monthly keyworker meetings throughout 2019.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy, these need to be updated to ensure they highlight the needs of each service user in relation to advocacy.	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication initial indicators that detail the level of support needed when communication. This is reviewed annually.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in all homes at any time. Staff will provide a space for service users to meet privately with visitors if they require.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**

Each resident has access to and retains control of personal property and possessions.	All service user have access to their own possessions at all times. Linen is laundered by staff and returned to service users.	
Each resident is supported to manage their own financial affairs.	1 resident has their own bank card and bank account. All other residents are supported financially by staff.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents in all homes are treated with dignity and respect by all staff	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	In all homes in this designated centre service users go to day services during the week. Requested days off are facilitated in this designated centre as the service users have expressed their wishes not to go 5 days a week. Activity planners were also visible in some homes that were filled in based on what the service users would like to do in the evenings and weekends.	
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	All homes in this designated centre were clean and in good structural repair with minor issues identified through the monthly environmental audit. All issues have been LANDesked and are being followed up by the PIC.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	

Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Staff cook all meals in this designated centre which allows service users to be involved in the planning and cooking of meals. It also allows service users to change their mind on what food they would like to eat.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is transitions planned into and out of this designated centre to try to improve the compatibility of service users living together.	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management	Ensure all risk assessments are update to the new format. Some risk assessments that have been converted to the new format have recording errors e.g. wrong review dates, not all areas filled in.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily checks are completed.	Ensure PEEPs are reviewed as they are not consistently completed correctly. Yes or no option needs to be ticked for all areas of the PEEPs to ensure that information is clear to any staff member working there. Ensure service users only have one PEEP for community- currently a number of service users have duplicate PEEPs. Ensure fire drills are recorded on all PEEPs A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own		Ensure all self-administration medication assessments are reviewed every 12 months

medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	1 service user missing a PRN protocol One service user has a PRN protocol that's not on Kardex.	
SAMs trained staff have in date SAMs training,	All SAMs trained staff had in date sams training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure all staff sign each policy to say they have read them.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Work needs to be completed to ensure printed rosters match what is on the system.
6	Ensure all staff complete and keep up to date with core competency training and refresher courses.
7	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
8	Each service users SURA documents should be reviewed annually (or sooner if required)
9	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
10	Complaints needs to be discussed at service user weekly meetings so all service users are aware of how to make a complaint.
11	Ensure all service users receive an OK Health Check in 2019 reviewed by a nurse to ensure appropriate clinical oversight.
12	Ensure all service users receive an AMR in 2019
13	PIC to ensure that all staff follow the agreed pathway for creating Health care plans.
14	Follow up on requests for behaviour support plans to be reviewed.
15	Ensure all safeguarding plans are reviewed within the correct timeframes.
16	Ensure all residents get monthly keyworker meetings throughout 2019.
17	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights

18	Ensure all HIQA notifications are sent to HIQA within the correct timeframes.
19	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
20	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
21	Ensure all risk assessments are update to the new format.
22	Ensure PEEPs are reviewed as they are not consistently completed correctly
23	A number of staff require fire safety training and on site fire drill training
24	Ensure all self-administration medication assessments are reviewed every 12 months
25	Ensure issues raised through service users surveys are addressed
26	Ensure issues raised through family and friends surveys are addressed.

Designated Centre 3

Location:	2 Hollyville, 3 Hollyville, Roseville
PIC:	Pam Daly
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

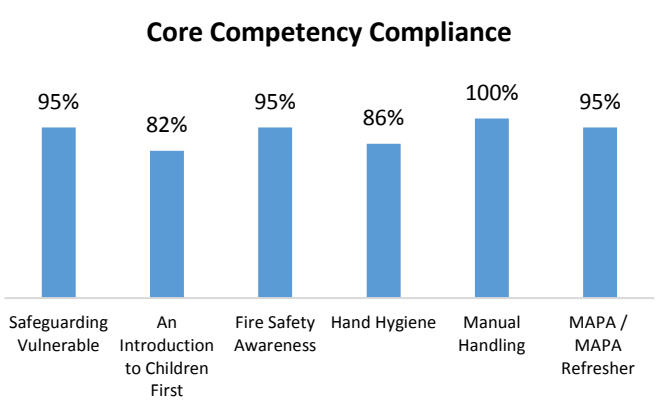
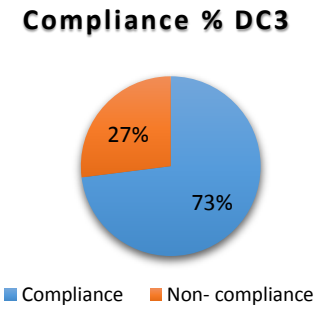
- I like helping to pick the food menu.
- Like cooking own meals.
- I love my home.
- I love my room and the garden.
- I do not like service user meetings.
- I would like to go back to horse riding in Kilcloon.
- I would like to do a course in Ballyfermot.
- I would like to do a cookery or art course.

Friends and Family Survey Feedback 2018

- (Family member) is very happy with the care they are getting and if he is happy we are happy.
- (Family member) has everything he needs there
- It is important to us that (family member is looked after with care and his needs are promptly met.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	The most up to date statement of purpose is available in each home in folder 1.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in each house.	Ensure all staff sign each policy to say they have read them. As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	1 WTE vacancy in this designated centre	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**2 Hollyville** **Shift allocation as per 2019 DNA;** 1 RN Day 1 HCA morn and even 1 RN Night **3 Hollyville** **Shift allocation as per 2019 DNA;** 1 HCA Sleepover 1 HCA 5-9 evening shift Mon- Fri 1 HCA Long day Sat- Sun **Roseville** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking 1 HCA 8-4pm Mon- Fri 1 SCW 4-8pm Mon - Fri 1 SCW 8-5.30pm Sat + Sun 1 HCA 11- 8pm Sat + Sun (early start is interchangeable between HCA/SCW)	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	The roster available in some homes did not always state the full complement of staff on duty. Work needs to be completed to ensure printed rosters match what is on the system.
Regulation 16: **Training & Development**	**Findings**	

Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff complete and keep up to date with core competency training and refresher courses.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	

Ensuring staff meetings take place monthly	Staff meetings took place monthly in each home throughout 2018. Organisational template was used and all minutes were available	
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	All notifiable incidents were sent to HIQA within the correct timeframes.	Continue to ensure all HIQA notifications are sent to HIQA within the correct timeframes throughout 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and recent complaints have been processed correctly as per organisational policy.	Ensure all complaints are documented on the complaints log.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have a personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	1 service user did not have an OK Health Check in 2018 (received an OK Health Check in Oct 2017 and Jan 2018).	Ensure all service users receive an OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	All service users had an AMR in 2018 by a GP.	Ensure all service users receive an AMR in 2019.
Ensure there is care plans in place for each identified need.	Majority of care plans in place were well documented. .	Ensure red initial indicators state when there is a care plan in place. PIC to ensure that all staff follow the agreed pathway for creating Health care plans.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**

Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	**2 Hollyville** 3 service users have up to date PBSPs **3 Hollyville** All PBSP in place are up to date and staff are aware of them	Ensure all staff are aware of all PBSPs
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	Number of restrictions in this designated centre; Locked front door, Locked car door Locked sharps press. Locked wardrobes at night for MH. All restrictions are brought to the restrictive practice committee regularly and have up to date protocols in place.	Continue to trial removing restrictions throughout 2019.
Regulation 8 **Protection**	**Findings:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	**2 Hollyville** 1 Safeguarding plans due for review	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training		Ensure all staff are up to date with safeguarding and children's first training
Regulation 9 **Residents rights**	**Findings**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings	Not all residents have had monthly keyworker meetings. Weekly service user meetings are taking place.	Ensure all residents get monthly keyworker meetings throughout 2019.

and weekly service user meetings.		
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy.	These need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
Regulation 10 **Communication**	**Findings**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users communication initial indicators that detail the level of support needed when communication.	These need to be updated to ensure they highlight the needs of each service user in relation to communication, some have not been updated in a number of years.
Regulation 11 **Visits**	**Findings**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in all homes at any time. Staff will provide a space for service users to meet privately with visitors if they require.	
Regulation 12 **Personal Possessions**	**Findings:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All service user have access to their own possessions at all times. Linen is laundered by staff and returned to service users.	
Each resident is supported to manage their own financial affairs.	10 residents have their own bank accounts. All other residents are supported financially by staff.	
Regulation 13 **General Welfare & Development**	**Findings:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect.	Residents in all homes are treated with dignity and respect by all staff	

All practices are person-centred and resident- focussed.		
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	In all homes in this designated centre there are service users who go to day services during the week. However in all homes there is service users who have days off throughout the week and some service users with no day service that are activated by residential staff.	
Regulation 17 **Premises**	**Findings:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	All homes in this designated centre were clean and in good structural repair with minor issues identified through the monthly environmental audit. All issues have been LANDesked and are being followed up by the PIC.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	
Regulation 18 **Food and Nutrition**	**Findings:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Staff cook all meals in this designated centre which allows service users to be involved in the planning and cooking of meals. It also allows service users to change their mind on what food they would like to eat. In Roseville service users enjoy cooking their own meals staff try to encourage healthy choices.	

Regulation 20 **Information for Individuals**	**Findings:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**Findings:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is transitions planned out of this Designated Centre.	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**Findings:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management. All risk assessments have been converted to the new format.	
Regulation 27 **Protection against Infection**	**Findings:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place. Ensuring good	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.

Infection Control procedures are in place.		
Regulation 28 **Fire Precautions**	**Findings:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly. Staff are trained in fire drills and staff training in evacuation procedures.	Daily checks are completed. All PEEPs were fully completed and tested.	A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**Findings:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker	All service users had a self-administration medication assessments completed in the past 12months.	Ensure all self-administration medication assessments are reviewed every 12 months
There is up to date PRN protocols in place.	A number of PRNs protocols were out of date across the designated centre.	Ensure all PRN protocols are updated as required.
SAMs trained staff have in date SAMs training,	All SAMs trained staff had in date training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure all staff sign each policy to say they have read them.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Work needs to be completed to ensure printed rosters match what is on the system.
6	Ensure all staff complete and keep up to date with core competency training and refresher courses.
7	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
8	Each service users SURA documents should be reviewed annually (or sooner if required)
9	Ensure all HIQA notifications are sent to HIQA within the correct timeframes throughout 2019.
10	Ensure all complaints are documented on the complaints log.
11	Ensure all service users receive an OK Health Check in 2019.
12	Ensure all service users receive an AMR in 2019.
13	PIC to ensure that all staff follow the agreed pathway for creating Health care plans.
14	Ensure all staff are aware of all PBSPs
15	Continue to trial removing restrictions throughout 2019.
16	Ensure all safeguarding plans are reviewed within the correct timeframes.
17	Ensure all staff are up to date with safeguarding and children's first training
18	Ensure all residents get monthly keyworker meetings throughout 2019.
19	Advocacy initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
20	Communication initial indicators need to be updated to ensure they highlight the needs of each service user in relation to communication, some have not been updated in a number of years.
21	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
22	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
23	Ensure all actions identified by the IPC Nurse are followed up with.
24	A number of staff require fire safety training and on site fire drill training
25	Ensure all self-administration medication assessments are reviewed every 12 months
26	Ensure all PRN protocols are updated as required.
27	Ensure service user issues raised from the survey are addressed
28	Ensure family issues raised from the survey are addressed

Designated Centre 4

Location:	Louisa Valley, Silken Vale, Castlevillage Walk
PIC:	Dolores Gorman
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

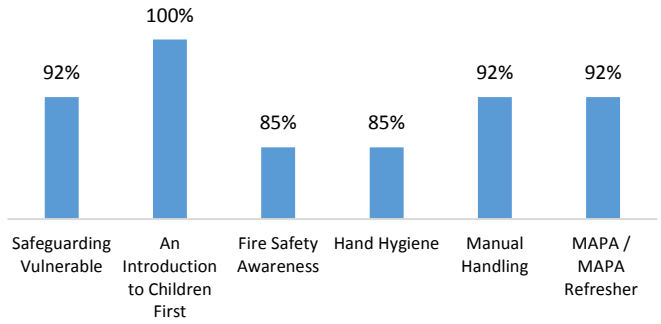
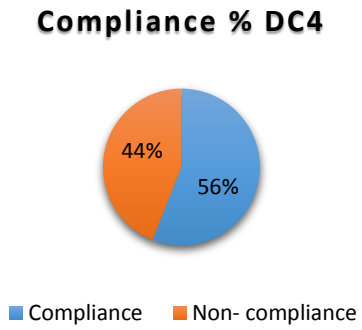
- Like consistent staff.
- Love living in Leixlip.
- Love the garden.
- Very happy in Silken Vale.
- I feel safe in my home.
- Would like more transport.
- I would like to change my job.
- I would like more staff so I can achieve more goals.
- Would like a new shower area.
- Would like handrails around the house.

Friends and Family Survey Feedback 2018

Family and friends surveys were distributed in January 2018 but unfortunately none were returned form this designated centre.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	The most up to date statement of purpose is available in each home in folder 1.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in each house.	Ensure all staff sign each policy to say they have read them. As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	1.5 WTE vacancy in this designated centre	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Louisa Valley** **Staffing allocation as per 2019 DNA;** 1 Waking HCA each night, 1 Staff full day each day (every second day this is a R/N), 1 HCA from 7am-11am Mon-Fri, 1HCA from 5pm-9pm Mon-Fri, 1 HCA from 8.30 - 5.30 Sat and Sun **Silken Vale** **Staffing allocation as per 2019 DNA;** 1 S/N sleepover Monday evening to Friday morning; 1 HCA from 4-8 pm mon-Thursday evening 1 WTE added in to cover 4 weekends per year (156 day hours - 56 sleepover hours) **Castlevillage Walk** **Staffing allocation as per 2019 DNA;** 1 S/O 4pm-9.30am MON-FRI (HCA), S/O 12-12pm Sat/ 12-10 Sun; 2 HCA 5-9pm Mon-Fri; 10-7.30pm HCA Sat / Sun	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	

Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff complete and keep up to date with core competency training and refresher courses.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**

Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings have not been taking place monthly in each home throughout 2018.	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place in all homes monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	All notifiable incidents were sent to HIQA within the correct timeframes.	Continue to ensure all HIQA notifications are sent to HIQA within the correct timeframes throughout 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and recent complaints have been processed correctly as per organisational policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have a personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	1 resident did not have an MDT meeting in 2018.	Ensure all service users have an MDT meeting in 2019.
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check in 2018.	
Ensure each resident has had an Annual Medical Review completed by a GP.	3 service users had no evidence on SURA of receiving an AMR in 2018 by a GP.	Ensure all service users receive an AMR in 2019.
Ensure there is care plans in place for each identified need.	Majority of care plans in place were well documented. .	PIC to ensure that all staff follow the agreed pathway for creating Health care plans.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	**Louisa Valley** One PBSP is out of date since 2016 needs to be reviewed. **Silken Vale**	Ensure there is follow up referrals for PBSPs to be reviewed as required.

	One service user has an up to date PBSP for day services. **Castlevillage Walk** 1 PBSP currently being reviewed by Psychology 1 service user is in contact with Psychology, no up to date PBSP in place currently	
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	Restrictions in this designated centre; Locked fridge and kitchen presses when staff are asleep at night All restrictions are brought to the restrictive practice committee regularly and have up to date protocols in place	Continue to trial removing restrictions or to ensure the least restrictive intervention is in place throughout 2019.
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	**Castlevillage Walk** Safeguarding plans are due for review **Silken Vale** Ensure all safeguarding plans clearly state if they are closed. If they are still open then they need to be reviewed. **Louisa Valley** Only day service safeguarding plans in place.	Ensure all safeguarding plans are reviewed within the correct timeframes. Ensure all safeguarding plans clearly state if they are closed.

All staff must receive safeguarding and Children's First Training		Ensure all staff are up to date with safeguarding training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have had monthly keyworker meetings. Weekly service user meetings are taking place.	Ensure all residents get monthly keyworker meetings throughout 2019.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy.	These need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users communication initial indicators that detail the level of support needed when communication.	These need to be updated for service users in Castlevillage Walk to ensure they highlight the needs of each service user in relation to communication, some have not been updated in the past 12 months.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in all homes at any time. Staff will provide a space for service users to meet privately with visitors if they require.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All service user have access to their own possessions at all times. Linen is laundered by staff and returned to service users.	

Each resident is supported to manage their own financial affairs.	Residents in Silken Vale are supported financially by family and staff. All other residents are supported financially by staff.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents in all homes are treated with dignity and respect by all staff	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	In all homes in this designated centre there are service users who go to day services during the week. In Louisa Valley there is 2 men who stay at home one has no day service and one is for health reasons.	
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	All homes in this designated centre were clean and in good structural repair with minor issues identified through the monthly environmental audit. All issues have been LANDesked and are being followed up by the PIC.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Staff cook all meals in this designated centre which allows service users to be involved in the planning and cooking of meals. It also allows service users to change their mind on what food they would like to eat. In Roseville service users enjoy cooking their own meals staff try to encourage healthy choices.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is transitions planned in and out of this Designated Centre due to service user incompatability.	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management. All risk assessments have been converted to the new format.	Ensure all risk assessments and risk register are updated to new format as per risk management policy.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily checks are completed. All PEEPs were fully completed and tested.	Ensure fire drills are recorded on all PEEPs A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and	1 service users requires the self-administration medication assessment to be reviewed.	Ensure all self-administration medication assessments are reviewed every 12 months

preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	There was no PRN protocol for 1 PRN in place.	Ensure all PRN protocols are updated as required.
SAMs trained staff have in date SAMs training,		Ensure recently trained SAMs staff complete assessments.

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure all staff sign each policy to say they have read them.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Ensure all staff complete and keep up to date with core competency training and refresher courses.
6	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
7	Each service users SURA documents should be reviewed annually (or sooner if required)
8	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place in all homes monthly.
9	Continue to ensure all HIQA notifications are sent to HIQA within the correct timeframes throughout 2019.
10	Ensure all service users have an MDT meeting in 2019.
11	Ensure all service users receive an AMR in 2019.
12	PIC to ensure that all staff follow the agreed pathway for creating Health care plans.
13	Ensure there is follow up referrals for PBSPs to be reviewed as required.
14	Continue to trial removing restrictions or to ensure the least restrictive intervention is in place throughout 2019.
15	Ensure all staff are up to date with safeguarding training
16	Ensure all safeguarding plans clearly state if they are closed.
17	Ensure all safeguarding plans are reviewed within the correct timeframes.
18	Ensure all residents get monthly keyworker meetings throughout 2019.
19	Communication initial indicators need to be updated for service users in Castlevillage Walk to ensure they highlight the needs of each service user in relation to communication, some have not been updated in the past 12 months.

20	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
21	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
22	Ensure all risk assessments and risk register are updated to new format as per risk management policy.
23	Ensure all actions identified by the IPC Nurse are followed up with.
24	Ensure fire drills are recorded on all PEEPs
25	A number of staff require fire safety training and on site fire drill training
26	Ensure all self-administration medication assessments are reviewed every 12 months
27	Ensure all PRNs have an up to date protocols in place.
28	Ensure recently trained SAMs staff complete assessments.
28	Ensure service user requests from service user survey are followed up.

Designated Centre 5

Location:	Beech Park, Cannonbrook, Westbury Drive
PIC:	Ronan Halpenny
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

Numerous attempts were made to get the PIC and staff to provide service users with the opportunity to fill in the service user surveys.

Service users were spoken to during all RPV visits. All service users stated that they were happy in their home.
Service users in Beechpark expressed their wishes to have the folders and computer moved out of the dining room..

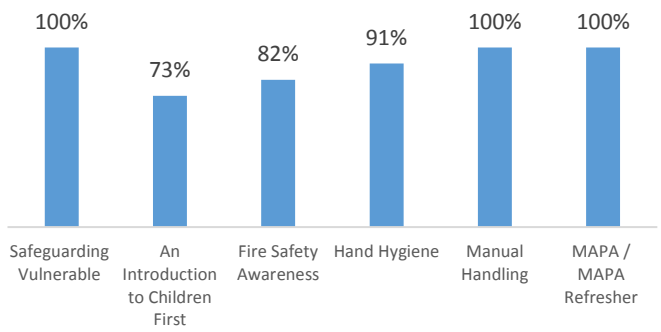
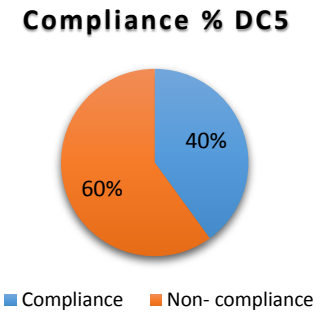
Friends and Family Survey Feedback 2018

- (Family member) enjoys her independence in Beechpark
- We are very satisfied that (family member) is getting the care and support she needs.
- Care has been in general very good and given (family member) a sense of independence

- There are ongoing issues with another resident, our understanding is that they are being addressed
- Staff have left and have not been replaced, this is not acceptable.
- Often Stewarts conduct box ticking exercises and sometimes there is genuine care and support
- Communication could improve the service.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	The most up to date statement of purpose was not available in each home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in each house.	Ensure all staff sign each policy to say they have read them. As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	0.5 HCA vacancy in this designated centre	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Beech Park** **Staffing complement as per 2019 DNA** 1 HCA sleepover 1 HCA 5-9 Mon-Fri, 1 HCA 10-7.30pm Sat Sun **Cannonbrook** **Staffing complement as per 2019 DNA** 1 HCA on waking nights 10pm-10am, 1 HCA 4pm-11pm Mon-Fri 1 HCA 5-9 Mon-Fri, 1 staff (SCW or HCA) 10am-10pm Sat, Sun, 1 staff (SCW/HCA) 8-8pm. In total 1 WTE SCW is allocated to this house, the relief for this role is HCA. **Westbury Drive** **Staffing complement as per 2019 DNA** 1 HCA sleepover each day	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	

Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff complete and keep up to date with core competency training and refresher courses.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here. Upon review there is numerous service users personal support plans that have not been updated annually.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	

Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly in each home throughout 2018.	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most notifiable incidents were sent to HIQA within the correct timeframes.	Ensure all HIQA notifications are sent to HIQA within the correct timeframes.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and recent complaints have been logged and have been processed correctly as per organisational policy.	Complaints needs to be discussed at service user weekly meetings so all service users are aware of how to make a complaint.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have a personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check in the past 12 months.	Ensure all service users receive an OK Health Check in 2019 reviewed by a nurse to ensure appropriate clinical oversight.
Ensure each resident has had an Annual Medical Review completed by a GP.	1 service users have no evidence on SURA of receiving an AMR in 2018.	Ensure all service users receive an AMR in 2019, documented in the correct place on SURA.
Ensure there is care plans in place for each identified need.	Some work required in this area. PIC to ensure that all staff follow the agreed pathway for creating Health care plans.	Ensure all health issues identified in the brief summary of issues section are documented in the red initial indicators. Ensure red initial indicators state when there is a care plan in place. Ensure all chronic and acute conditions have a care plan in place. All needs sheets need to be deleted as they're no longer used in the service

		Ensure all OK Health Checks are reviewed by a nurse.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	**123 Beechpark** One service users PBSP has not been reviewed since 2017 **Cannonbrook** 2 service users have evidence of having Psychology input	Follow up on requests for behaviour support plans to be reviewed.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A No restrictions in this Designated Centre	
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	**123 Beechpark** 2 open safeguarding plans in place **Westbury** 1 open safeguarding plan in place	Ensure all safeguarding plans are reviewed within the correct timeframes.

All staff must receive safeguarding and Children's First Training	Staff are up to date with safeguarding training	Ensure all staff complete Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have had monthly keyworker meetings. Weekly service user meetings are taking place.	Ensure all residents get monthly keyworker meetings throughout 2019.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy, these need to be updated to ensure they highlight the needs of each service user in relation to advocacy.	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	Some service user's communication initial indicators have not been updated in 4 years. These should detail the level of support needed when communicating and be reviewed annually.	Ensure all service users communication initial indicators are reviewed as these are out of date.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in all homes at any time. Staff will provide a space for service users to meet privately with visitors if they require.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**

Each resident has access to and retains control of personal property and possessions.	All service users have access to their own possessions at all times. Linen is laundered by staff and returned to service users.	
Each resident is supported to manage their own financial affairs.	Residents are supported financially by staff.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents in all homes are treated with dignity and respect by all staff	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	In all homes in this designated centre service users go to day services during the week.	
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	All homes in this designated centre were clean and in good structural repair with minor issues identified through the monthly environmental audit. All issues have been LANDesked and are being followed up by the PIC.	Service users in Beechpark have requested that the staff bedroom is used to store all folders instead of their dining room.
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Staff cook all meals in this designated centre which allows service users to be involved in the planning and cooking of meals. It also allows service users to change their mind on what food they would like to eat.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is transitions planned into and out of this designated centre to try to improve the compatibility of service users living together.	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management	Ensure all risk assessments and risk register are update to the new format.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily checks are completed.	Ensure PEEPs are reviewed as numerous PEEPs were found out of date. A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his		Ensure all self-administration medication assessments are completed and reviewed every 12 months

or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	Number of out of date protocols to go with PRNs. Staff said they had contacted surgery regarding this	Ensure PRN protocols don't go out of date.
SAMs trained staff have in date SAMs training,	All SAMs trained staff had in date sams training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure all staff sign each policy to say they have read them.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Ensure all staff complete and keep up to date with core competency training and refresher courses.
6	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
7	Each service users SURA documents should be reviewed annually (or sooner if required)
8	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place in all homes monthly.
9	Continue to ensure all HIQA notifications are sent to HIQA within the correct timeframes throughout 2019.
10	Complaints needs to be discussed at service user weekly meetings so all service users are aware of how to make a complaint.
11	Ensure all service users receive an OK Health Check in 2019 reviewed by a nurse to ensure appropriate clinical oversight.
12	Ensure all service users receive an AMR in 2019, documented in the correct place on SURA.
13	Ensure all health issues identified in the brief summary of issues section are documented in the red initial indicators.
14	Ensure red initial indicators state when there is a care plan in place.
15	Ensure all chronic and acute conditions have a care plan in place. All needs sheets need to be deleted as they're no longer used in the service.
16	Ensure all OK Health Checks are reviewed by a nurse.
17	Follow up on requests for behaviour support plans to be reviewed.
18	Ensure all safeguarding plans are reviewed within the correct timeframes.
19	Ensure all staff complete Children's first training

20	Ensure all residents get monthly keyworker meetings throughout 2019.
21	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
22	Follow up on request from service users in Beechpark have requested that the staff bedroom is used to store all folders instead of their dining room.
23	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
24	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
25	Ensure all risk assessments and risk register are update to the new format.
26	Ensure all actions identified by the IPC Nurse are followed up with.
27	Ensure PEEPs are reviewed as numerous PEEPs were found out of date.
28	A number of staff require fire safety training and on site fire drill training
29	Ensure all self-administration medication assessments are completed and reviewed every 12 months
30	Ensure PRN protocols don't go out of date.
31	Ensure all issues brought up through the family and friends survey are followed up.

Designated Centre 6

Location:	Oakcourt Close, Woodfarm Acres, Riversdale Park, St. Andrews Green
PIC:	Michelle Bethel
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)
Only 2 surveys received back from this DC

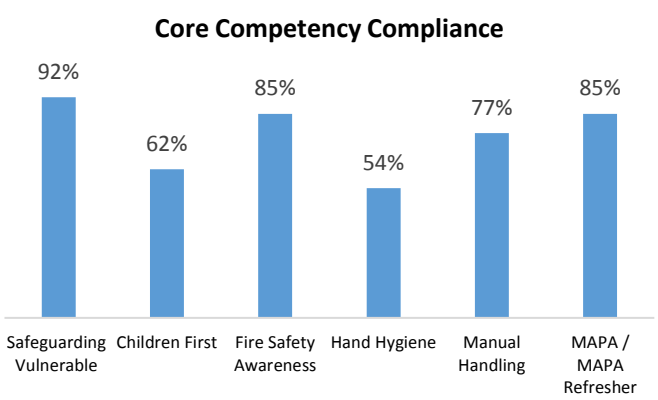
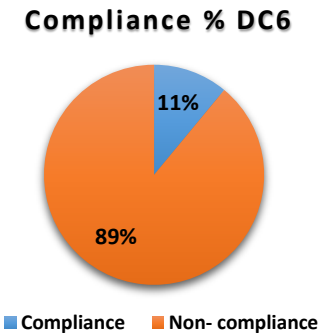
- Like living here.
- Would like an ensuite toilet

Friends and Family Survey Feedback 2018

- Important that (family members) needs are met and continuity of staff to support him.
- I think it is good that (family member) has her own room in the community where she is cared for in a family atmosphere.
- Families feel they are kept up to date about the care and support their family members receive.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	The most up to date statement of purpose was not available in each home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in each house.	Ensure all staff sign each policy to say they have read them. As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	1.5 WTE vacancy	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Oakcourt Close** 1 HCA Sleepover 4-9.30pm, Evenings and weekends hours of social support (6 HOURS PER WEEK EVENINGS + 4 HOURS SATURDAY AND 4 HOURS SUNDAY) + 6 hours retirement support day for A.T. **Woodfarm Acres 2** 1 Sleepover each day HCA + 1 retirement day each week for CL (9.30-4.30 - 7 hours) - S/N **Woodfarm Acres 4** HCA Night S/O + 5 hours retirement day per week per person (10 hours S/N per week total - HL and MHB) **Riversdale** Agreed staffing allocation per shift HCA 5-9pm Mon- Fri HCA 10-7.30 Sat + Sun HCA S/0 4pm- 9.30am **St Andrews Green** 1 HCA S/O 4pm-9.30am (3pm-9am Thur 3pm-12pm Fri) , 12-12pm Sat/ Sun 1 HCA Evening 5-9pm Mon- Fri + 10- 7.30pm Sat- Sun	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	

Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff complete and keep up to date with core competency training and refresher courses.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**

Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly in each home throughout 2018.	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most notifiable incidents were sent to HIQA within the correct timeframes	Ensure ALL notifiable incidents are sent to HIQA within the correct timeframes.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place however these need to be updated to the new complaints log. There isn't a record of many complaints being processed from this designated centre.	Complaints needs to be discussed at service user weekly meetings so all service users are aware of how to make a complaint.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have a personal support plan that is available to them or their representatives.	Intimate care plans are out of date and need to be reviewed.
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	2 service users in this designated centre have no evidence of receiving an OK Health Check in 2018	Ensure all service users receive an OK Health in 2019 reviewed by a nurse to ensure appropriate clinical oversight.
Ensure each resident has had an Annual Medical Review completed by a GP.	4 service users have no evidence on SURA of receiving an AMR in 2018.	Ensure all service users receive an AMR in 2019, documented in the correct place on SURA.
Ensure there is care plans in place for each identified need.	Some work required in this area. PIC to ensure that all staff follow the agreed pathway for creating Health care plans.	Red initial indicators should only identify chronic and acute conditions and guide staff to the correct care plans. Ensure if there is a care plan identified on the red initial indicators that it is created. Ensure all care plans guide practice and are evaluated effectively.

		Needs sheets are obsolete in this service and should be deleted and valid information converted to a health care plan
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	**Oakcourt** Staff confidently explained the controls in place. **Riversdale** PBSP was created in 2014, no psychology input since PBSP was created in 2016, no psychology input since **St Andrews** One service users PBSP was reviewed recently by Psychology. One service users PBSP was created by the CNS in Behaviour in 2016- no input since	Follow up on requests for behaviour support plans to be reviewed.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A	
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	

All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	**Oakcourt** There is up to date safeguarding plans in this home that have decreased the occurrence of incidents. **Riversdale** There is up to date safeguarding plans in this home that have decreased the occurrence of incidents **Woodfarm** Safeguarding plans need to be reviewed to ensure they are still relevant and if not closed off. **St Andrews** Safeguarding plans need to be reviewed to ensure they are still relevant and if not closed off.	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have had monthly keyworker meetings. Weekly service user meetings are taking place in some areas but not all. They can be very generic with the same thing written every week.	Ensure all residents get monthly keyworker meetings throughout 2019. Ensure effective weekly service user meetings take place that provide direction and guidance for the house each week.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy, these need to be updated to ensure they highlight the needs of each service user in relation to advocacy.	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.

Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication initial indicators that detail the level of support needed when communication. This is reviewed annually.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in all homes at any time. Staff will provide a space for service users to meet privately with visitors if they require.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All service users have access to their own possessions at all times. Linen is laundered by staff and returned to service users as soon as possible.	
Each resident is supported to manage their own financial affairs.	Service users are supported financially by staff	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents in all homes are treated with dignity and respect by all staff during audits.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	In all homes in this designated centre service users go to day services during the week. Activity planners were also visible in some homes that were filled in based on what the service users would like to do in the evenings and weekends.	

Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.		**Riversdale** Painting required in hall as there is marks and dirt on the walls. **Woodfarm** One service users bedroom to be assessed for size as it is very small. **Oakcourt** Painting required in service users bedroom due to the moving of cupboards from one room to another
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Staff cook all meals in this designated centre which allows service users to be involved in the planning and cooking of meals. It also allows service users to change their mind on what food they would like to eat.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**

A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is planned transitions out of this designated centre.	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management	Ensure all risk assessments are update to the new format.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**

Making sure daily checks on equipment and escape routes. Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly. Staff are trained in fire drills and staff training in evacuation procedures.	Daily checks are completed.	Ensure PEEPs are reviewed as they are not consistently completed correctly. Yes or no option needs to be ticked for all areas of the PEEPs to ensure that information is clear to any staff member working there. Ensure all areas of PEEPs have information included. Ensure fire drills are recorded on all PEEPs A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		These could not be identified on SURA. Ensure all residents have a self-administration of medication assessment completed annually and recorded on SURA.
There is up to date PRN protocols in place.	All PRNs had up to date protocols in place	
SAMs trained staff have in date SAMs training,	All SAMs trained staff had in date SAMs training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure all staff sign each policy to say they have read them.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Ensure all staff complete and keep up to date with core competency training and refresher courses.
6	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
7	Each service users SURA documents should be reviewed annually (or sooner if required)
8	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place in all homes monthly.
9	Continue to ensure all HIQA notifications are sent to HIQA within the correct timeframes throughout 2019.
10	Complaints needs to be discussed at service user weekly meetings so all service users are aware of how to make a complaint.
11	Intimate care plans are out of date and need to be reviewed.
12	Ensure all service users receive an OK Health in 2019 reviewed by a nurse to ensure appropriate clinical oversight.
13	Ensure all service users receive an AMR in 2019, documented in the correct place on SURA.
14	Red initial indicators should only identify chronic and acute conditions and guide staff to the correct care plans.
15	Ensure if there is a care plan identified on the red initial indicators that it is created.
16	Ensure all care plans guide practice and are evaluated effectively.
17	Needs sheets are obsolete in this service and should be deleted and valid information converted to a health care plan
18	Follow up on requests for behaviour support plans to be reviewed.
19	Ensure all safeguarding plans are reviewed within the correct timeframes.
20	Staff members requires safeguarding training
21	Staff members requires Children's first training
22	Ensure all residents get monthly keyworker meetings throughout 2019.
23	Ensure effective weekly service user meetings take place that provide direction and guidance for the house each week.
24	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
25	Follow up on maintenance requests.
26	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
27	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
28	Ensure all risk assessments are update to the new format.
29	Ensure all actions identified by the IPC Nurse are followed up with.
30	Ensure PEEPs are reviewed as they are not consistently completed correctly. Yes or no option needs to be ticked for all areas of the PEEPs to ensure that information is clear to any staff member working there.

31	Ensure all areas of PEEPs have information included.
32	Ensure fire drills are recorded on all PEEPs.
33	A number of staff require fire safety training and on site fire drill training.
34	Ensure service users requests from service user survey are followed up
35	Ensure family requests from surveys are followed up

Designated Centre 7

Location:	Westhaven, Weston Way, Weston Court
PIC:	John Flanagan
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

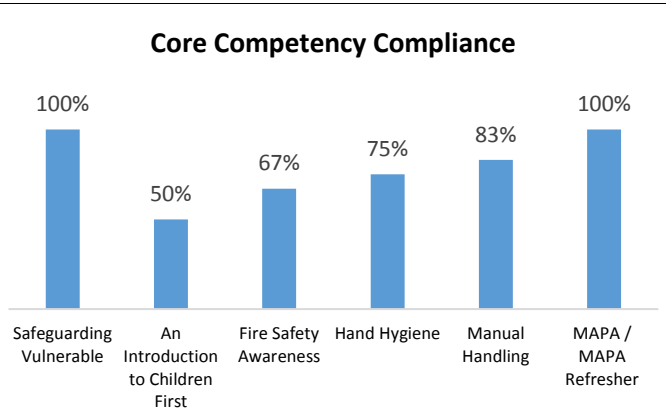
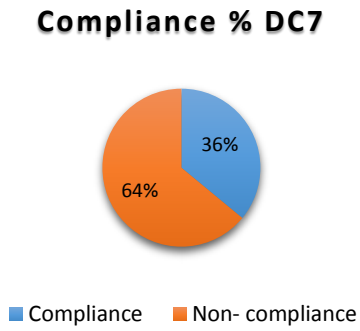
- Like my home and my bedroom.
- I like my timetable of activities.
- Would like to go out for more meals
- Would like my bedroom to be repainted and curtains fixed.
- I would like a heavy duvet for my bed.

Friends and Family Survey Feedback 2018

- I am always filled in on any questions I have about (family member) both in Rossecourt and Weston Way
- Important to us that (family members) health and diet are looked after as he is overweight.
- Important to us that (family member) attends Sunday Mass.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	The most up to date statement of purpose was not available in each home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in each house.	Ensure all staff sign each policy to say they have read them. As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	No vacancies in this designated centre.	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Weston Way** **Staffing Complement as per the 2019 DNA:** 1 sleepover staff; 1 8AM - 8 PM each day; 1 6pm - 11 pm Monday-Friday; 1 8am-8pm every second Saturday 1 of the above lines is a Nurse / all others are HCA **Weston Court** **Staffing Complement as per the 2019 DNA:** 1 waking HCA each night; 1 staff from 7am-10 am and from 5pm-10 pm Monday to Friday; 1 staff from 10am to 10 pm Saturday and Sunday, 1 staff from 8 am - 10 p.m. Saturday and Sunday (one line is a staff nurse line) **Westhaven** **Staffing Complement as per the 2019 DNA:** 1 HCA 8am-8pm, 1 HCA waking night 8-8, 1 HCA 5-9pm Mon-Fri, 1 HCA 8am-8pm Sat Sun every second weekend,	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	The roster available in some homes did not always state the full complement of staff on duty, however it was confirmed that the workforce planning system did have the right information. Work needs to be completed to ensure printed rosters match what is on the system.
Regulation 16: **Training & Development**	**Findings**	

Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff complete and keep up to date with core competency training and refresher courses.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**

Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly in each home.	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most notifiable incidents were sent to HIQA within the required timeframes.	Ensure ALL notifiable incidents are sent to HIQA within the required timeframes in 2019
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place. There isn't a record of many complaints being processed from this designated centre.	Complaints needs to be discussed at service user weekly meetings so all service users are aware of how to make a complaint.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have a personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check in 2018 by a Nurse	
Ensure each resident has had an Annual Medical Review completed by a GP.	All service received an AMR in 2018 by a GP.	
Ensure there is care plans in place for each identified need.	PIC to ensure that all staff follow the agreed pathway for creating Health care plans.	Red initial indicators should only identify chronic and acute conditions and guide staff to the correct care plans. Ensure if there is a care plan identified on the red initial indicators that it is created. Ensure all care plans guide practice and are evaluated effectively.

		Needs sheets are obsolete in this service and should be deleted and valid information converted to a health care plan Review two service users Health promotion section of SURA to ensure they don't need any health care plans.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	**Weston Way** All PBSP have been reviewed by the CNS in Behaviour **Weston Court** All BSPs need to be reviewed as these are out of date. Please refer to psychology for review. **Westhaven** No behaviour support plans currently in place 2 have been referred for psychology input but have not had any involvement to date. A follow up referral is needed for these service users.	Ensure there is follow up referrals for those that need PBSPs reviewed.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	Restrictions in Weston way: Angel guard and clip on gate. These have both been through the restrictive practice committee and are the least restrictive.	Continue to trial removing restrictions in 2019.

Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	**Weston Way** Safeguarding plans are out of date and need to be reviewed **Weston Court** Safeguarding plans on SURA are out of date and need to be reviewed. **Westhaven** Safeguarding plans on SURA are out of date and need to be reviewed.	Ensure all safeguarding plans are reviewed within the correct timeframes. If safeguarding plans are no longer relevant please close off.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training. Staff members requires Children's first training.
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have had monthly keyworker meetings. Weekly service user meetings are taking place in some areas but not all. They can be very generic with the same thing written every week.	Ensure all residents get monthly keyworker meetings throughout 2019. Ensure effective weekly service user meetings take place that provide direction and guidance for the house each week.

All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy.	These need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication initial indicators that detail the level of support needed when communication. This is reviewed annually.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in all homes at any time. Staff will provide a space for service users to meet privately with visitors if they require.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents are in control of their own possessions. Linens are laundered by staff and returned to service users as soon as possible.	
Each resident is supported to manage their own financial affairs.	All residents are supported financially by staff	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents in all homes are treated with dignity and respect by all staff during audits.	
Do residents have a meaningful day that corresponds with what	In all homes in this designated centre service users go to day services during the week.	

is recorded in the resident's personal plan/ PATH?	Retirement days are also facilitated in this designated centre as there is an ageing population. Activity planners were also visible in some homes that were filled in based on what the service users would like to do in the evenings and weekends.	
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.		**Weston Way** Cleaning required- laundry room and bathroom Hole in chimney breast needs to be fixed. Significant dampness on sitting room ceiling. **Weston Court** Ceiling in the sitting room has a big hole in it and needs to be repaired. Service user's ensuite bathroom is not fit for purpose and was assessed by technical services in June 2018 but there has been no amendments to date. **Westhaven** The floor around the door going from the hall to the kitchen needs to be fixed as the widening of the door affected the floor.
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Staff cook all meals in this designated centre which allows service users to be involved in the planning and cooking of meals. It also allows service users to change their mind on what food they would like to eat. There is a food planner up on the walls but staff explained that choices made can be altered throughout the week depending on what service users want on the day.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management	Ensure all risk assessments are update to the new format. Some risk assessments currently available in this designated centre are old and out of date.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audits were completed at the start of 2018	Ensure all actions identified during IPC audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily checks are completed.	Ensure PEEPs are reviewed as they are not consistently completed correctly. Yes or no option needs to be ticked for all areas of the Ensure review date shave not passed Ensure fire drills are recorded on all PEEPs A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his	**Westhaven** All service users have completed self administration medication assessments in the past 12 months. **Weston Court** All self administration medication assessments were out of date.	Ensure all residents have a self-administration of medication assessment completed annually and recorded on SURA.

or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker	**Weston Way** These could not be identified on SURA.	
There is up to date PRN protocols in place.	All PRNs had up to date protocols in place	
SAMs trained staff have in date SAMs training,	All SAMs trained staff had in date sams training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure all staff sign each policy to say they have read them.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Work needs to be completed to ensure printed rosters match what is on the system.
6	Ensure all staff complete and keep up to date with core competency training and refresher courses.
7	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
8	Each service users SURA documents should be reviewed annually (or sooner if required)
9	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
10	Complaints needs to be discussed at service user weekly meetings so all service users are aware of how to make a complaint.
11	PIC to ensure that all staff follow the agreed pathway for creating Health care plans.
12	Review two service users Health promotion section of SURA to ensure they don't need any health care plans.
13	Ensure ALL notifiable incidents are sent to HIQA within the required timeframes in 2019
14	Ensure there is follow up referrals for those that need PBSPs reviewed.
15	Continue to trial removing restrictions in 2019.
16	Ensure all safeguarding plans are reviewed within the correct timeframes. If safeguarding plans are no longer relevant please close off.
17	Staff members requires safeguarding training.
18	Staff members requires Children's first training.
19	Ensure all residents get monthly keyworker meetings throughout 2019.
20	Ensure effective weekly service user meetings take place that provide direction and guidance for the house each week

21	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
22	Advocacy initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
23	Ensure all identified environmental issues are followed up with technical services.
24	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
25	A Critical Incident Review will be completed after every unplanned hospital admission.
26	Ensure all risk assessments are update to the new format. Some risk assessments currently available in this designated centre are old and out of date.
27	Ensure all actions identified during IPC audit are followed up.
28	Ensure PEEPs are reviewed as they are not consistently completed correctly. Yes or no option needs to be ticked for all areas of the PEEP.
29	Ensure review dates have not passed
30	A number of staff require fire safety training and on site fire drill training
31	Ensure fire drills are recorded on all PEEPs
32	Ensure all residents have a self-administration of medication assessment completed annually and recorded on SURA.
33	Follow up any service users issues that came from service user survey.
34	Follow up any family issues that came from family surveys.

Designated Centre 8

Location:	House 25 and Honeybee Apartment
PIC:	Fiona Forde
Date of Publication:	April 2019

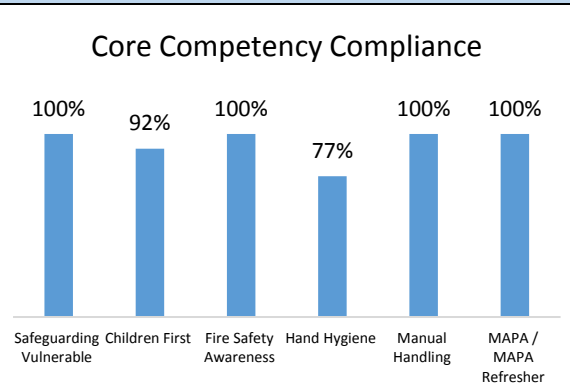
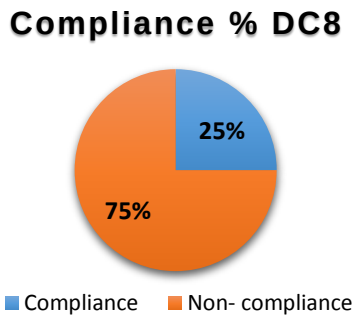
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

No service user surveys were returned from this designated centre despite reminders provided to the PIC.

Friends and Family Survey Feedback 2018

No family or friends returned surveys for the residents of Designated Centre 25

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose available in folder 1.	Ensure all staff read and understand statement of purpose
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**		Some policies in folder require updating and reissuing. Staff signing policies dated 2014/ 2016 in 2019.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a person in charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	Have full complement of nursing staff.	Complement of 15.7 staff. Currently 12 staff allocated to house. Care staff vacancies being filled by agency staff. All residents have 1:1 staff assigned when in the house and 2:1 staff assigned when on outings.
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	Yes when regular staff are on.	Reduce the number of agency staff in this designated centre by filing core vacancies.

The person in charge must ensure there is a planned and actual roster.	This is available in the house	Ensure actual roster details all staff on duty in the designated centre per day.
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		8 staff require in house fire drill training. Ensure all staff have hand hygiene training
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.

Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Actions are being tracked through the Compliance Plans and Registered Provider visit feedback.	
Ensuring staff meetings take place monthly		Meetings are not taking place monthly. Person in charge needs to ensure there is a schedule of meetings to guarantee they take place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A There is no volunteers here at present.	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	All notifiable incidents were sent to HIQA within the correct timeframe	Ensure all notifiable incidents are sent to HIQA within the correct timeframe in 2019
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	No. 14 complaints and compliments folder is available in the house which contains complaints forms and log. No complaints have been received since 2014.	Ensure complaints are discussed and explained to all service users so they are aware of the process and what a complaint is.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	Yes all residents had an OK Health Check completed by a nurse.	
Ensure each resident has had an Annual Medical Review completed by a GP.	All residents received an AMR by a GP in 2018	
Ensure there is care plans in place for each identified need.	It was noted in Registered Provider visit that health care plans greatly improved since previous visits. Plans are clear, consistent with findings of OK Health Check and initial indicators. All components linking together.	
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	All behaviour support plans are up to date and are reviewed by the CNS in Behaviour and Psychology as are incidents related to behaviour.	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.

	All staff are knowledgeable of the contents of the plans and some have received positive behaviour support training.	
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	Locked external doors for 2 service users. Locked kitchen door at certain times for one service user. Window restrictors for one service user. All restrictions have a protocol in place and are reviewed every 3 months by the Restrictive Practice Committee to ensure they are the least restrictive. There was a decrease in restrictive practices in these homes during 2018.	Continue to trial removing restrictions in 2019.
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	1 interim safeguarding plan in place for bruising which is planned to be discontinued following completion of a Trust in Care investigation. Other safeguarding plans reviewed in February and sent to CHO on 03/02/19 to close off. None of the issues now present.	
All staff must receive safeguarding and Children's First Training	All staff are up to date with safeguarding training.	Ensure all staff complete Children's First Training.
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker	3 service users take part in meaningful service user meetings. 1 service user refuses to take part.	

meetings and weekly service user meetings.	All service users have been taking part in monthly key worker meetings	
All residents have access to advocacy services and information about their rights?	There is SAGE involvement in this residence.	Ensure all residents are provided with information on advocacy services available to them.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All residents have communication supports in place in their personal support plan.	Initial indicators for communication supports need to be updated annually
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	This designated centre comprises of four individual apartments and so have their own private communal areas for receiving visitors.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All service users have access to their own possessions at all times.	
Each resident is supported to manage their own financial affairs.	3 residents finance is managed by their families. 1 resident is supported to manage her own funds.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	It was observed in registered provider audits that staff speak respectably to service users and all actions are completed are person centred.	

Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	Since the reconfiguration of the house the residents have the facility for more individual interaction and social integration.	
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	All areas in the apartments were clean and tidy. Honey Bee apartment is very homely and very well decorated and personalised. The outside space and individual garden space is a huge improvement. All apartments have adequate circulating space both inside and outside.	The whole area would benefit from painting and redecoration. All apartments with the exception of Honeybee require some interior decoration and personalisation
Environmntal Audit **Actions from environmental audits are completed in an effective manner.**		<u>Actions from environmental audit awaiting completion</u> The type and positioning of the bed in one residents apartment needs to be addressed to ensure proper cleaning can be undertaken. Shower hose and head not fixed to the wall in another apartment, left hanging over the bath. Sharp edge in shower area in the bathroom, risk of resident banging his head while taking a shower.
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Residents have access to kitchen and have started cooking snacks and light meals. This is proving very beneficial to the residents. Residents take part in meal planning for rolling menu from CPU.	Continue to work on cooking the foods service users request in the homes.

Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is no planned transitions from this home in 2019.	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk.
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	Infection control audit completed in January 2019	A review of actions identified will happen throughout the year.

Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily fire checks completed	All Peeps need to be reviewed to ensure the review dates are appropriate, fire drills are recorded and all are available in the fire evacuation folder. A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker	All service users have a completed self-administration medication assessment within the last year	
There is up to date PRN protocols in place.	Yes all protocols are available in the kardex folder	
SAMs trained staff have in date SAMs training,	All staff have in date SAMs training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Some policies in policy folder require updating and reissuing. Staff signing policies dated 2014/ 2016 in 2019.
2	Fill core vacancies and reduce the number of agency staff working in this DC
3	Ensure actual roster details all staff on duty in the designated centre per day.
4	Ensure all staff receive in house fire drill training

5	It is important that all staff receive effective supervisions in 2019
6	Each service users SURA documents should be reviewed annually (or sooner if required)
7	Person in charge needs to ensure there is a schedule of staff meetings to guarantee they take place monthly.
8	Ensure complaints are discussed and explained to all service users so they are aware of the process and what a complaint is
9	All staff in this area must receive training on MAPA (refresher) and positive behaviour support training.
10	Continue to trial removing restrictions in 2019.
11	All staff must complete Children's First Training
12	Initial indicators for communication supports need to be updated annually
13	All apartments with the exception of Honeybee require some interior decoration and personalisation
14	The type and positioning of a residents bed needs to be addressed to ensure proper cleaning can be undertaken.
15	Shower hose and head not fixed to the wall in another apartment, left hanging over the bath.
16	Sharp edge in shower area in the bathroom, risk of resident banging his head while taking a shower.
17	Continue to work on cooking the foods service users request in the homes.
18	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
19	Ensure a Critical Incident Review is completed after every unplanned hospital admissions.
20	Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
21	All Peeps need to be reviewed to ensure the review dates are appropriate, fire drills are recorded and available in the fire folder.
22	A number of staff require fire safety training and on site fire drill training
23	Ensure all notifiable incidents are sent to HIQA within the correct timeframe in 2019

Designated Centre 9

Location:	Woodlands 23, Buck House
PIC:	Aedin Fleming Brooks
Date of Publication:	April 2019

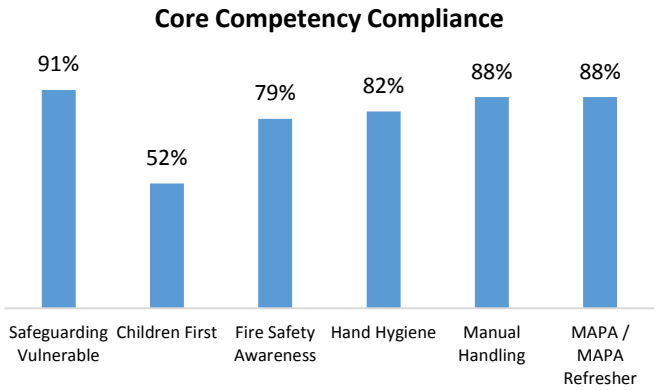
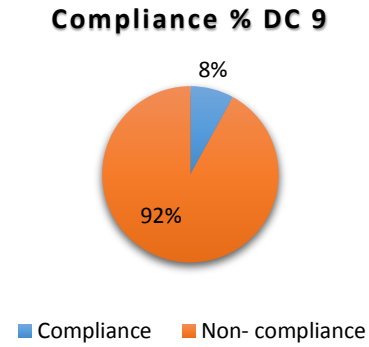
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- Don't like strangers in my house.
- Would like more goodies in the press
- Would like to be able to lock my bedroom door.
- Too many people live in this house
- Don't always feel safe.
- I need more storage space
- I am waiting for my trike to be adapted for me
- Would like a better choice of food

Friends and Family Survey Feedback 2018

- Good caring staff, good communication from staff as to how (family member) is doing.
- Last time we were up I though (family members) room could be done up a bit.
- Always phone me if something is wrong or has happened.
- Would like (family member) to have more than one visit home a year.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is currently no vacancies in this designated centre	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	Buck House- Yes there is one regular HCA staff member working with the service user during the day and no staff in the home at night. This works very well with nightly supervision from Woodlands 23.	

	Woodlands 23- 1 Registered Nurse and 4 Care Staff on duty daily. It was noted during registered provider visits that these staffing levels were sufficient to meet the needs of the residents.	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to and reviewed by the Programme Manager.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff complete - Safeguarding training - Children's First training - Fire safety awareness training - On site fire drill training - Hand hygiene training - Manual handling training - Mapa/ Mapa refresher training
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.

Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA records should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly throughout 2018.	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly. PIC needs to use the organisational template to ensure key issues are discussed each month
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	PIC of this designated centre changed at the start of 2019 and confirmed that any incidents that occurred while she was PIC have been notified to HIQA within the correct timeframes.	
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre.	

Knowing who to contact for support/decisions if the PIC is absent.	Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy. One home in this DC had no recorded complaints on their complaints log.	Ensure complaints are spoken about at service user weekly meetings so service users are aware of how to make a complaint.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check completed in 2018 by a nurse.	

Ensure each resident has had an Annual Medical Review completed by a GP.	All service users had an AMR completed in 2018 by a GP.	
Ensure there is care plans in place for each identified need.	Discrepancies exist between summary section of OK health Check, Initial Indicators and Current Care Plans. One resident had two conditions documented in the summary section of the Ok Health Check but had 5 care plans in place. Components not connecting. Another service user had Care plans missing as per issues raised in the OK Health Check.	PIC needs to ensure that this information is fed back to staff completing OK Health Check and reviewing red initial indicators to ensure they are completed as per the agreed pathway.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	All PBSP's were reviewed in 2018. All staff are aware of the contents of the PBSPs and the recommended controls to put in place when necessary.	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	Sleep suit. Body suit. Locked Doors. Bed Alarm. Door Alarm. All restrictions have a restrictive practice protocol in place.	Continue to trial removing restrictions in 2019.
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms have been fully completed and follow up action plans have been implemented.	Ensure all staff are who was responsible to complete the follow up form or the implementation of same.

All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is up to date safeguarding plans in this home.	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	All residents have had monthly keyworker meetings however it was noted during that the quality was very poor and generic, there was no details in them.	Ensure keyworker meetings are personal to the service user and provide clear guidance.
All residents have access to advocacy services and information about their rights?	Staff advised that they were unaware that any advocate was working with the house or individuals at the present time.	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	Each service user has a communications section in their personal support plan however this has not been updated in a number of years.	Ensure all service users communication section of their personal support plan is up to date and is reviewed annually.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to Woodlands 23 and there is space available for residents to meet with their friends/ family members.	

Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have access to their own possessions and clothes are kept in their own rooms. Linens are laundered regularly and returned to the service user.	
Each resident is supported to manage their own financial affairs.	One service user in this Designated Centre has his own bank account and bank card. All other services users are supported by staff to manage their finances.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	During previous visits to this home residents were not involved in any conversation as staff sat and spoke to each other in the sitting room. One resident was left lying across a couch for a prolonged period of time (approximately one hour) and no staff member checked on him or offered him any type of assistance or any form of interaction. Meal times were also observed to be rushed and mass managed.	In late 2018 the management of this designated centre changed. The new PIC over this designated centre has put in significant work to improve the previous practices in this home with a view to continuing this work in 2019. PIC to ensure practices in the home are person centred and resident focused.
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	It appears that there is no plan for the day unless the day activation staff have organised this. Staff unsure of how many PATH goals had been achieved to date. Service user in single dwelling requires 2:1 when out in the company, staff stated that they are very restricted on activities.	Ensure a review of PATHs are completed to ensure all activities are in line with service users' needs and wishes.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**

Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	Both homes need maintenance work to be completed as listed in both RP visits. Woodlands 23 is not homely or welcoming and requires redecoration to complete same.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	All environmental audit actions were LANDesked.	PIC to ensure all LANDesk actions are followed up.
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Begin to work on cooking the foods service users request in the homes.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.

Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	**MIRANDA**	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk.
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC Audit was completed in 2018	Ensure actions are followed up
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.**	Daily fire checks are being completed in these homes. All PEEPs are fully completed and up to date.	A number of staff require fire safety training and on site fire drill training

Staff are trained in fire drills and staff training in evacuation procedures.		
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker	All service users have a completed self-administration medication assessment within the last year	
There is up to date PRN protocols in place.	Yes all protocols are available in the kardex folder	
SAMs trained staff have in date SAMs training,	No record available during visit. Nurse on duty at all times to administer medication.	Ensure all SAMs trained staff have up to date SAMs training

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure all staff complete Safeguarding training
5	Ensure all staff complete Children's First training
6	Ensure all staff complete Fire safety awareness training
7	Ensure all staff complete On site fire drill training

8	Ensure all staff complete Hand hygiene training
9	Ensure all staff complete Manual handling training
10	Ensure all staff complete Mapa/ Mapa refresher training
11	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
12	Each service users SURA records should be reviewed annually (or sooner if required)
13	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
14	PIC needs to use the organisational template to ensure key issues are discussed each month
15	Ensure complaints are spoken about at service user weekly meetings so service users are aware of how to make a complaint
16	Ensure OK Health Checks, red initial indicators and Care Plans are completed as per the agreed pathway.
17	Continue to trial removing restrictions in 2019.
18	Ensure all staff are who was responsible to complete the follow up form or the implementation of same.
19	Ensure all safeguarding plans are reviewed within the correct timeframes.
20	Ensure keyworker meetings are personal to the service user and provide clear guidance.
21	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
22	Ensure all service users communication section of their personal support plan is up to date and is reviewed annually.
23	PIC to ensure practices in the home are person centred and resident focused.
24	Ensure a review of PATHs are completed to ensure all activities are in line with service users' needs and wishes.
25	PIC to ensure all LANDesk actions are followed up.
26	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
27	Ensure a Critical Incident Review will be completed after every unplanned hospital admissions.
28	Ensure actions from IPC audit are followed up
29	Ensure all SAMs trained staff have up to date SAMs training
30	Follow up on all service user requests identified in service user survey
31	Follow up on all family requests identified in family and friends survey

Designated Centre 10

Location:	Bungalow 8
PIC:	Louise Butler
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- Enjoy the food here
- Enjoy sitting in the sunroom
- Would like a bigger room with more comfortable seats for visitors
- Has begun to choose going outdoors rather than complete indoor activities
- Would like more sensory activities
- Enjoys massages

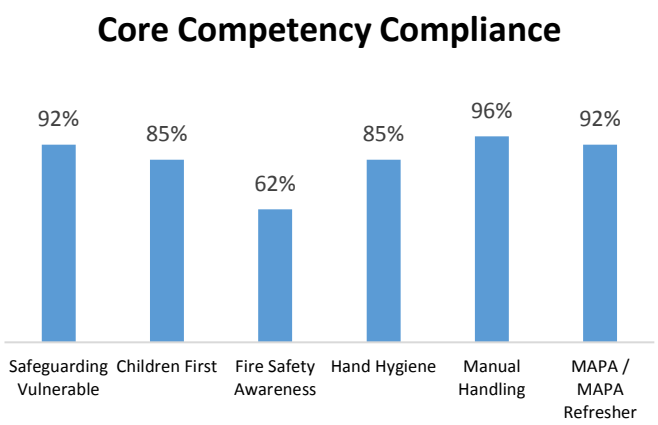
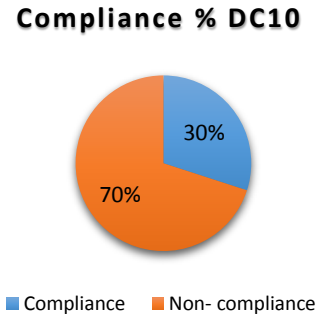
No service users ticked or stated that they were unhappy with any of the sections of the survey

Friends and Family Survey Feedback 2018

- Important that (family member) is well looked after with care and compassion.
- Important that we can visit (family member) at any time- staff always very accommodating.
- We find weekly massage sessions are very beneficial to (family member)

- Only hear from Stewarts when I ring up- would like one person to correspond with regarding (family member).
- Would like more interaction with the family.
- Turnover of staff in recent times is very high not beneficial to service users or their families
- Would like if financial statements were more specific
- Continuity of care is important and that all (family members) needs are met and that (family member) is happy

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	No vacancies	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	There is a good skills mix in this house. Day time core staff; 1 Staff Nurse, 4 HCA, 2 Day Activation Staff and 1 Household Staff	

The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies including refreshers in the required timeframes.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do.	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.

Personal supports plans is in place and up to date		
Regulation 23: Governance and Management	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings are taking place monthly and the agreed organisational template is being used.	
Regulation 30 Volunteers/Students	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 Notification of Incidents	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	All incidents that were notifiable to HIQA were sent in within the correct timeframe in 2018.	Continue to ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
Regulation 32/33 Absence of the Person in Charge	**Findings**	**Comments and suggestions for improvement**
Person in Charge Knowing who to contact for support/decisions if the PIC is absent.	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 Complaints Procedure	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner Easy to read guidance and forms available to all Service Users	There is a complaints log in place and all complaints are processed in line with the policy.	

All complaints recorded on complaints log		

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	One service user did not have an OK Health Check completed in 2018.	Ensure all service user have a completed OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	Five service user had no AMR identified on SURA by a GP last year.	Ensure all service user have a completed AMR in 2019
Ensure there is care plans in place for each identified need.		There was poor linkage across OK Health Check, initial indicators and care plans. One resident (C.F.) had three issues identified in the summary section of the OK health check and had nine initial indicators, two of which related to the OK health check. PIC needs to ensure that this information is fed back to staff completing OK Health

		Check and reviewing red initial indicators to ensure they are completed as per the agreed pathway.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	All PBSP were reviewed in 2018 by Psychology All staff are aware of the contents of the PBSPs and the recommended controls to put in place when necessary.	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A	
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is up to date safeguarding plans in this home and staff are aware of them and the controls put in place to keep services uers safe.	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training

Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	All residents have had monthly keyworker meetings and a weekly service user meeting.	
All residents have access to advocacy services and information about their rights?	All service users have up to date initial indicators regarding advocacy and the information that is available to them.	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	Each service user has a communications section in their personal support plan that is updated annually.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to this home. In addition to the living area there is a sensory room, music room and family room where the residents can spend time.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have full access to all their possessions at all times. Linen is laundered and returned to service users as soon as possible	
Each resident is supported to manage their own financial affairs.	All service users have staff support them with their finances.	

Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Very good interaction observed between staff and residents. A nice homely, caring and relaxed environment evident in the house. All residents given time and attention with ADL's and daily routine.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	There have been some staff changes in the house that will provide the opportunity for more activation and social recreation A second day activation staff has been assigned to the house in recent weeks and the staff team are currently identifying the personal needs of the residents and developing plans accordingly. There have been additional hours allocated to the household staff. A further two hours has been provided in the evening which will provide the opportunity for staff to engage the residents in some evening activation or recreational programmes.	PIC to ensure this time is used effectively by staff and that an increase in activities with service users is well documented.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. **The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.**	House is very homely. All residents have their own bedroom with adequate storage for clothing and personal items. All bedrooms personalised and decorated to meet individual needs and preferences.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	All actions from environmental audits are followed up by the PIC in an effective manner.	

Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Where possible service users go to the shop to pick out foods.	Work on cooking in the home to provide more choice in the meals provided to service users.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is due to be 2 service user to move out of this home by the end of 2019.	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management	Ensure all risk assessments are update to the new format.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	An IPC audit was completed in Jan 2019	Ensure all actions from IPC audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily fire checks completed	A number of staff require fire safety training and on site fire drill training. Review date section incomplete on all PEEPS this needs to be amended.
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his	Each resident has had a self-administration of medication assessment completed in the past 12 months.	

or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	All PRNs are up to date and available in the kardex folder in the home	
SAMs trained staff have in date SAMs training,		This is currently being completed. PIC to ensure it is done within the required timeframe.

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff complete all core competencies including refreshers in the required timeframes.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Each service users SURA documents should be reviewed annually (or sooner if required)
7	Ensure all service user have a completed OK Health Check in 2019.
8	Ensure all service user have a completed AMR in 2019
9	PIC needs to ensure that this information is fed back to staff completing OK Health Check and reviewing red initial indicators to ensure they are completed as per the agreed pathway
10	Ensure all safeguarding plans are reviewed within the correct timeframes.
11	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
12	PIC to ensure that increased staffing levels reflects an increase in activities with service users and is well documented.
13	Work on cooking in the home to provide more choice in the meals provided to service users.
14	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019
15	A Critical Incident Review will be completed after every unplanned hospital admissions.
16	Ensure all risk assessments are update to the new format.
17	Review date section incomplete on all PEEPS this needs to be amended.
18	Ensure all actions from IPC audit are followed up.
19	Ensure SAMs trained staff complete training within the required timeframe.

21	Ensure any issues raised by service users in the service users survey are addressed
22	Ensure any issues raised by families in the family surveys are addressed

Designated Centre 11

Location:	Bungalow 7, Bungalow 9
PIC:	Mary Redmond
Date of Publication:	April 2019

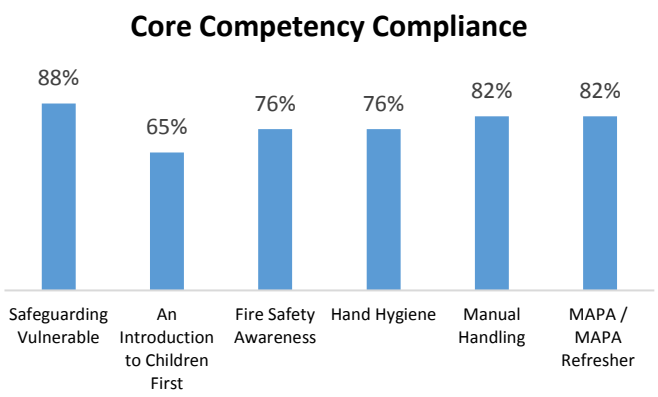
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

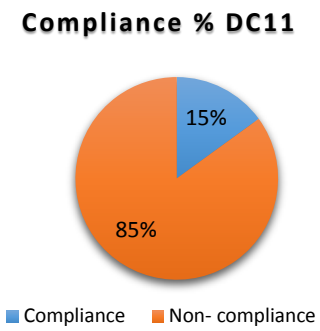
- I would like to have WIFI in my home so I can use my tablet.
- I am not always happy with the meal choices from the central kitchen
- Lack of transport limits my choices.
- When social events take place in the great hall there is no meal options for me as I am on a pureed diet.
- I would like the garden to be wheelchair accessible.
- I would like more sensory equipment.
- I would like to go to more sporting events.
- Would like to attend events for girls my age.
- I like getting to visit my family

Friends and Family Survey Feedback 2018

- We would like to be informed if (family member) is having any medical
- We are very pleased and appreciative of the care (family member) gets.
- We feel that (family member) is happy and particular enjoys his outings.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	1.1 WTE Vacancies	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Bungalow 7** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking	

	1 RN Night Waking located in B.7 (Provides support to other service areas at night) 1 RN Day 8-8.15pm 3 HCA Day 8-8.15pm (with exception of 12-4pm Mon-Fri, 8-9am and 6pm-8pm Sat +Sun, where it drops to 2 staff) **Bungalow 9** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking 1 RN Day 8-8.15pm 4HCA Day 8- 8.15pm 1 Day Service	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies including refreshers in the required timeframes.

All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: Records	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. Personal supports plans is in place and up to date	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: Governance and Management	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings did not take place monthly across the designated centre.	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
Regulation 30 Volunteers/Students	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 Notification of Incidents	**Findings**	**Comments and suggestions for improvement**

Ensuring we report all HIQA notifiable incidents.	Most incidents that were notifiable to HIQA were sent in within the correct timeframe in 2018.	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	

Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 Healthcare.	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check completed in 2018.	Ensure all service user have a completed OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	Four service user had no AMR identified on SURA by a GP last year.	Ensure all service user have a completed AMR in 2019
Ensure there is care plans in place for each identified need.	Bungalow 7 Review red initial indicators and ensure they are relevant and relate back to care plans in place. What is written in red initial indicators does not always relate to the OK health check. Not always a health care plan for issues identified in OK assessment Evaluations section in health care plans do not always evaluate the plan. Ensure this is done effectively explaining why the plan does or does not remain the same. Bungalow 9 Health care plans are poor- some are missing titles, there are duplicates and some need to be deleted/ deactivated.	Significant work is required around health care plans and red initial indicators.
Regulation 7 Positive Behaviour Support	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	All PBSPs are up to date Psychology input has been requested for 1 resident,	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.

There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	There is sleepsuits in place in this designated centre. This has been brought to and reviewed by the restrictive practice committee	Continue to trial removing restrictions in 2019.
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	N/A	
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have been receiving monthly keyworker meetings throughout 2018. Service user meetings were not taking place weekly and need to be reviewed to ensure they are meaningful.	Ensure all service users receive monthly keyworker meetings in 2019 Ensure weekly service user meetings are taking place.

All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy.	These need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have initial indicators regarding communication.	These need to be updated to ensure they highlight the needs of each service user in relation to communication, some have not been updated in a number of years.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to the homes in this designated centre at any time. Staff will provide privacy to residents and visitors as required.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have full access to all their possessions at all times. Linen is laundered and returned to service users as soon as possible	
Each resident is supported to manage their own financial affairs.	All service users have staff support them with their finances.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	All staff speak respectably to all service users.	

Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	Bungalow 7 All service users go to day service or school.	Meaningful activities to be reviewed as they are limited in the house when residents aren't at day service s or school.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	House is very homely. All residents have their own bedroom with adequate storage for clothing and personal items. All bedrooms personalised and decorated to meet individual needs and preferences.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	All actions from environmental audits are followed up by the PIC in an effective manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Where possible service users go to the shop to pick	Work on cooking in the home to provide more choice in the meals provided to service users.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**

A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management	Ensure all risk assessments and risk register are updated to the new format.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	An IPC audit was completed in 2019	Ensure all actions from IPC audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**

Making sure daily checks on equipment and escape routes. Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly. Staff are trained in fire drills and staff training in evacuation procedures.	Daily fire checks completed	Review PEEPs to ensure they are completed correctly. Yes or No box needs to be ticked on all PEEPs. Delete duplicate PEEPs. Ensure all staff have up to date fire safety awareness training,
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker	Each resident has had a self-administration of medication assessment completed in the past 12 months.	
There is up to date PRN protocols in place.	Two PRN protocols are not in place for 2 PRNS.	
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff complete all core competencies including refreshers in the required timeframes.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
7	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
8	Each service users SURA documents should be reviewed annually (or sooner if required)
9	Ensure all service user have a completed OK Health Check in 2019.
10	Ensure all service user have a completed AMR in 2019
11	Significant work is required around health care plans and red initial indicators.
12	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.
13	Follow up on referral for Psychology input.
14	Continue to trial removing restrictions in 2019.
15	Staff members requires safeguarding training
16	Staff members requires Children's first training
17	Ensure all service users receive monthly keyworker meetings in 2019
18	Ensure weekly service user meetings are taking place.
19	Advocacy initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
20	Communication initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
21	Meaningful activities to be reviewed as they are limited in the house when residents aren't at day service s or school.
22	Work on cooking in the home to provide more choice in the meals provided to service users.
23	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019
24	A Critical Incident Review will be completed after every unplanned hospital admissions.
25	Ensure all risk assessments and risk register is updated to the new format.
26	Ensure all actions from IPC audit are followed up.
27	Review PEEPs to ensure they are completed correctly. Yes or No box needs to be ticked on all PEEPs.
28	Delete duplicate PEEPs.
29	Ensure all staff have up to date fire safety awareness training,
30	Ensure all actions from IPC audit are followed up.

31	Ensure all PRNs have an up to date protocol in place.
32	Ensure all service users issues raised from the service users survey are addressed.
33	Ensure all family issues raised from the family survey are addressed.

Designated Centre 12

Location:	Woodlands 22
PIC:	Aisling Brennan
Date of Publication:	April 2019

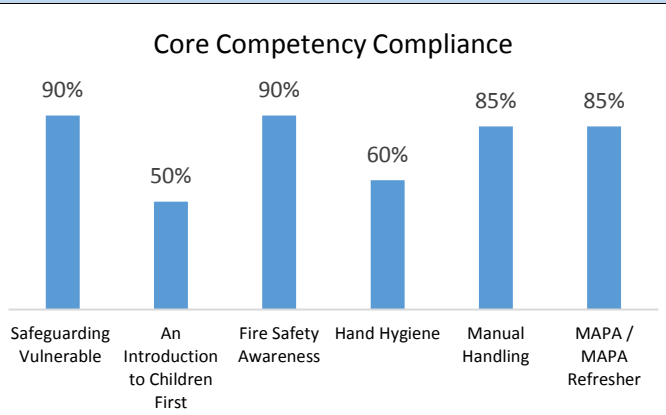
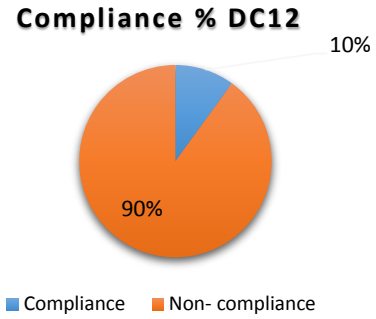
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

Numerous requests were made to the Person in Charge to ask service users with the support form staff to complete the service users survey but unfortunately non were received back from this designated centre

Friends and Family Survey Feedback 2018

Surveys were sent to all families in January 2019 unfortunately none were returned for this designated centre.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Programme Manager acting as a Person in Charge as the organisation aims to hire a Person in Charge	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	1.5 WTE Vacancies	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Shift allocation as per 2019 DNA;** 1 HCA Night Waking 1 RN Day 8-8.15pm 3 HCA Day 8-8.15pm	

	1 Day Service	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies including refreshers in the required timeframes.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do.	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.

Personal supports plans is in place and up to date		
Regulation 23: Governance and Management	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly across the designated centre.	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
Regulation 30 Volunteers/Students	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 Notification of Incidents	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that were notifiable to HIQA were sent in within the correct timeframe in 2018.	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
Regulation 32/33 Absence of the Person in Charge	**Findings**	**Comments and suggestions for improvement**
Person in Charge Knowing who to contact for support/decisions if the PIC is absent.	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 Complaints Procedure	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner	There is a complaints log in place and all complaints are processed in line with the policy.	

Easy to read guidance and forms available to all Service Users **All complaints recorded on complaints log**		

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check completed in 2018.	Ensure all service user have a completed OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	Two service user had no AMR identified on SURA by a GP last year.	Ensure all service user have a completed AMR in 2019
Ensure there is care plans in place for each identified need.	Ensure all health issues are summarised in the brief issues section at the end of the OK Health Check Red initial indicator do not always point to all care plans.	Ensure staff follow the organisational pathway for completing care plans.

Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	All PBSPs were due for review in March 2019	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	There is a number of restrictions in this home; Body suit Sleep suit Locked doors	There is plans to begin trailing a reduction in restrictions to improve service user's quality of life. This will commence at the start of April.
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans		Number of Safeguarding plans are due for review or if no longer necessary closed off.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**

Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have been receiving monthly keyworker meetings throughout 2018. Service user meetings were not taking place weekly and need to be reviewed to ensure they are meaningful.	Ensure all service users receive monthly keyworker meetings in 2019 Ensure weekly service user meetings are taking place.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy.	These need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have initial indicators regarding communication.	These need to be updated to ensure they highlight the needs of each service user in relation to communication, some have not been updated in a number of years.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to the homes in this designated centre at any time. Staff will provide privacy to residents and visitors as required.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have full access to all their possessions at all times. Linen is laundered and returned to service users as soon as possible	
Each resident is supported to manage their own financial affairs.	All service users have staff support them with their finances.	

Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	All staff speak respectably to all service users.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?		Meaningful activities to be reviewed as they are limited in the house.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. **The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.**	House is very homely. All residents have their own bedroom with adequate storage for clothing and personal items. All bedrooms personalised and decorated to meet individual needs and preferences.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	27/10/2018 was last environmental audit.	Need to ensure environmental audit is completed monthly
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Where possible service users go to the shop to pick	Work on cooking in the home to provide more choice in the meals provided to service users.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management. Risk register and risk assessment were completed in the new format.	
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**		Ensure all actions from IPC audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily fire checks completed. All PEEPs are fully updated and tested.	Ensure all staff have up to date fire safety awareness training,
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and	Each resident has had a self-administration of medication assessment completed in the past 12 months.	

preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	All PRNS have in date protocols	
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff complete all core competencies including refreshers in the required timeframes.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
7	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
8	Each service users SURA documents should be reviewed annually (or sooner if required)
9	Ensure all service user have a completed OK Health Check in 2019.
10	Ensure all service user have a completed AMR in 2019
11	Ensure staff follow the organisational pathway for completing care plans.
12	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.
13	There is plans to begin trailing a reduction in restrictions to improve service user's quality of life. This will commence at the start of April.
14	Number of Safeguarding plans are due for review or if no longer necessary closed off.
15	Staff members requires safeguarding training
16	Staff members requires Children's first training
17	Ensure all service users receive monthly keyworker meetings in 2019

18	Ensure meaningful weekly service user meetings are taking place.
19	Advocacy initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
20	Communication initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
21	Meaningful activities to be reviewed as they are limited in the house.
22	Need to ensure environmental audit is completed monthly
23	Work on cooking in the home to provide more choice in the meals provided to service users.
24	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019
25	A Critical Incident Review will be completed after every unplanned hospital admissions.
26	Ensure all actions from IPC audit are followed up.
27	Ensure all staff have up to date fire safety awareness training,

Designated Centre 15

Location:	Bungalow 2, Farmhouse
PIC:	Kathleen Brien
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

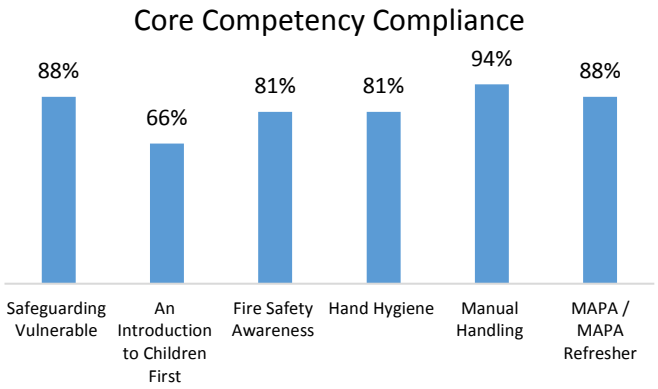
- I am not happy with noise from other residents
- Unhappy with other residents going into my room
- I would like a new bed.
- More staff to do 1 to 1 activities
- Would be nice to have a larger living space and a new bathroom/ shower room.
- I enjoy home cooked fresh meals.
- Would like my bedroom painted.
- Would like my cat to have his own house.
- Would like a gazebo to sit out in the garden in.
- Happier when regular staff are on.
- I would like to go to the library more.
- Would like more football, rugby, outdoor activities.
- Would like more multi-sensory time.
- Would like a relaxation room for when the weather is bad.
- Would like to go to the air show again.

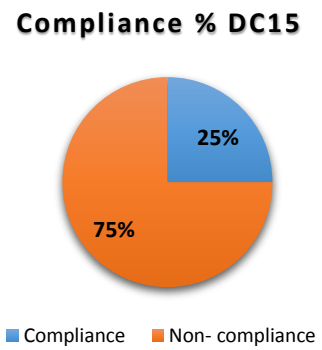
Friends and Family Survey Feedback 2018

- I am always made welcome and find (family member) very relaxed and happy.
- Very impressed with the effort staff have put in getting to know (family member) and how to communicate with him
- Caring and constant staff in the Farmhouse

- Would love to see more sensory sessions
- Relief staff are not always aware that (family member) is deaf. When Mum rings they often say would you like to talk to your son. Mum finds this very upsetting.
- Would like to know what his money is spent on.
- Would like more outings and social activities.
- Should a bigger room become available I would be happy if you would consider it for (family member).
- Would like (family member) involved in more areas in Kilcloon to vary his day.
- I would like more structure/ support in the evenings.
- Would like more training regarding laundry.
- Would like more interaction with social workers.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge assigned to this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	No Vacancies	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Bungalow 2** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking 1 SN 8-8.15pm	

	2 HCA 8-8.15pm 1 Day Service **Farmhouse** **Shift allocation as per 2019 DNA;** 1 HCA Day 1 HCA Night	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies including refreshers in the required timeframes.

All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings take place monthly in this designated centre.	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**

Ensuring we report all HIQA notifiable incidents.	Most incidents that were notifiable to HIQA were sent in within the correct timeframe in 2018.	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	

Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 Healthcare.	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check completed in 2018.	Ensure all service user have a completed OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	All service users had an AMR by a GP in 2018.	Ensure all service user have a completed AMR in 2019
Ensure there is care plans in place for each identified need.	Review care plans to ensure all identified issues require a Health Care Plan	Ensure staff follow the organisational pathway for completing care plans.
Regulation 7 Positive Behaviour Support	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	Bungalow 2 2 BSPs out of date since December 2018. Farmhouse All PBSPs are currently being reviewed or need to be reviewed by Psychology	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A	
Regulation 8 Protection	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and	All NIMs forms are completed and follow up action forms are completed.	

neglect in line with safeguarding policy.		
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	Bungalow 2 Ensure all safeguarding plans are reviewed in an effective and timely manner and if no longer needed closed off. Farmhouse All safeguarding plans are up to date	Number of Safeguarding plans are due for review or if no longer necessary closed off.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have been receiving monthly keyworker meetings throughout 2018. Service user meetings were taking place weekly	Ensure all service users receive monthly keyworker meetings in 2019 Ensure weekly service user meetings are meaningful and give direction and guidance for the week ahead.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy.	These need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication	All service users have initial indicators regarding communication.	These need to be updated to ensure they highlight the needs of each service user in relation to communication, some have not been updated in a number of years.

supports required and this is outline din their plan.		
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to the homes in this designated centre at any time. Staff will provide privacy to residents and visitors as required.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have full access to all their possessions at all times. Linen is laundered and returned to service users as soon as possible	
Each resident is supported to manage their own financial affairs.	All service users have staff support them with their finances.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	All staff speak respectably to all service users. Staff had very comprehensive knowledge of all service users and tailored activities around their likes and dislikes.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?		A review of PATH and goals would be helpful to ensure that all activities that take place are meaningful to the service users involved.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**

Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	Staff have worked hard to make this homely. However the shower room needs to be renovated as staff find it very difficult to attend to personal care. Bedrooms in bungalow 2 are very small with the exception of one resident who lives in a converted room at the back of the house.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	Environmental audits take place monthly and PIC follows up with all actions in a timely manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Where possible service users go to the shop to help to do the food shopping.	Work on cooking more in the home to provide more choice in the meals provided to service users. This also allows service users to be involved in the planning and preparing stages of the meals.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.

Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management.	Ensure all risk assessments and risk register are updated to the new format as per the risk management policy.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit was completed at the start of 2019	Ensure all actions from IPC audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.**	Daily fire checks completed. All PEEPs are fully updated and tested.	Ensure all staff have up to date fire safety awareness training,

Staff are trained in fire drills and staff training in evacuation procedures.		
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker	Each resident has had a self-administration of medication assessment completed in the past 12 months.	
There is up to date PRN protocols in place.	All PRNS have in date protocols	
SAMs trained staff have in date SAMs training,	Yes	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff complete all core competencies including refreshers in the required timeframes.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Each service users SURA documents should be reviewed annually (or sooner if required)
7	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.

8	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
9	Ensure all service user have a completed OK Health Check in 2019.
10	Ensure all service user have a completed AMR in 2019
11	Ensure staff follow the organisational pathway for completing care plans.
12	Review care plans to ensure all identified issues require a Health Care Plan
13	Follow up on request for PBSPs to be reviewed by CNS in Behaviour and Psychology.
14	Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.
15	There is plans to begin trailing a reduction in restrictions to improve service user's quality of life. This will commence at the start of April.
16	Number of Safeguarding plans are due for review or if no longer necessary closed off.
17	Staff members requires safeguarding training
18	Staff members requires Children's first training
19	Ensure all service users receive monthly keyworker meetings in 2019
20	Ensure meaningful weekly service user meetings are taking place.
21	Advocacy initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
22	Communication initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
23	A review of PATH and goals would be helpful to ensure that all activities that take place are meaningful to the service users involved.
24	Work on cooking more in the home to provide more choice in the meals provided to service users.
25	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019
26	A Critical Incident Review will be completed after every unplanned hospital admissions.
27	Ensure all risk assessments and risk register are updated to the new format as per the risk management policy.
28	Ensure all actions from IPC audit are followed up.
29	Ensure all staff have up to date fire safety awareness training,

Designated Centre 16

Location:	Bungalow 4, Bungalow 6
PIC:	Mary Priestly
Date of Publication:	April 2019

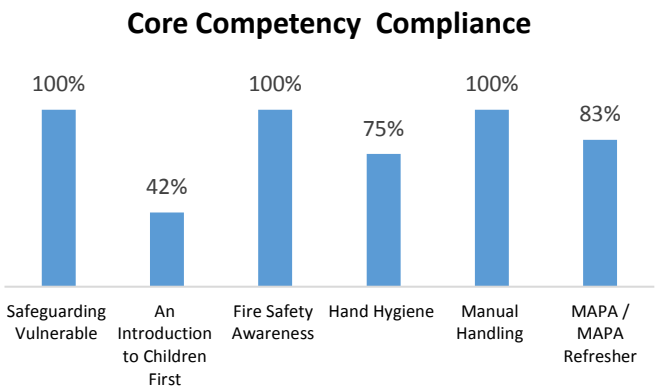
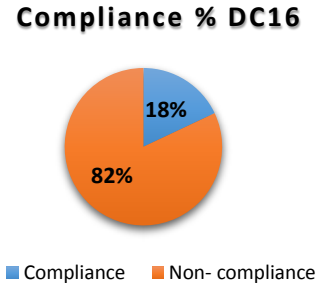
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- Fellow behaviour can make me anxious.
- I would like to go to more music sessions.
- I would like a bigger bedroom.
- I would like an armchair in my bedroom.
- I would like less noise in the house.
- I would like more holidays.
- I would like to have a family room.
- Would like to go on more outings.
- I would like to go to Kinvara more.
- I would like a safer way to access the garden, it's not wheelchair accessible.
- Would like garden to be more sensory.
- Would like more 1 to 1 social activation.
- I would like to go to visit the beach more often.
- Would like more access to wheelchair transport.
- No facilities in the bathroom or shower room for me to have a shower or a bath

Friends and Family Survey Feedback 2018

- Every time we visit we meet friendly and regular staff.
- We are happy with our family members care.
- It is important to us that our family member has permanency in her living unit.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge assigned to this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	No, there is vacancies in this designated centre	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Bungalow 4** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking 1 SN 8-8.15pm	

	2 HCA 8-8.15pm 1 Day Service **Bungalow 6** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking 2 Staff Day 8-8.15pm (Includes 1 RN line)	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies including refreshers in the required timeframes.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.

Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly in this designated centre.	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that were notifiable to HIQA were sent in within the correct timeframe in 2018.	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	

Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	One resident did not have an MDT meeting in 2018	Ensure all service users have an MDT meeting in 2019.
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check completed in 2018.	Ensure all service user have a completed OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	3 service users have no evidence on SURA of receiving an AMR by a GP in 2018.	Ensure all service user have a completed AMR in 2019

Ensure there is care plans in place for each identified need.	Red initial indicators need to be reviewed and guide to care plans. There is poor linkage between OK Health check, care plans and red initial indicators..	Ensure staff follow the organisational pathway for completing care plans.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	Bungalow 4 All PBSPs are up to date	Not all staff in this area have received training on MAPA (refresher)
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A All restrictive practices from this Designated Centre were discontinued in 2018. All staff spoke very positively about this.	
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	Bungalow 4 All interim safeguarding plans identified in the home need to be reviewed as it has been 6 months since they were completed. Bungalow 6 All safeguarding plans were in relation to a service user who has since moved from this residency.	Number of Safeguarding plans are due for review or if no longer necessary closed off.

All staff must receive safeguarding and Children's First Training	All staff have completed safeguarding training.	Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all residents have been receiving monthly keyworker meetings throughout 2018. Service user meetings were also not taking place weekly and need to be reviewed to ensure they are meaningful	Ensure all service users receive monthly keyworker meetings in 2019 Ensure weekly service user meetings are meaningful and give direction and guidance for the week ahead.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy.	These need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have initial indicators regarding communication.	These need to be updated to ensure they highlight the needs of each service user in relation to communication, some have not been updated in a number of years.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to the homes in this designated centre at any time. Staff will provide privacy to residents and visitors as required.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**

Each resident has access to and retains control of personal property and possessions.	All residents have full access to all their possessions at all times. Linen is laundered and returned to service users as soon as possible	
Each resident is supported to manage their own financial affairs.	All service users have staff support them with their finances.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	All staff speak respectably to all service users.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?		A review of PATH and goals would be helpful to ensure that all activities that take place are meaningful to the service users involved.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. **The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.**	Bungalow 4 Bathroom does not meet the needs of a service user who has a deterioration in mobility. An email was sent to the line managers with no response received to date.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	Environmental audits have not been taking place monthly.	Ensure environmental audits take place monthly and that PIC follows up with all actions in a timely manner.
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Where possible service users go to the shop to help to do the food shopping.	Continue to cook meals in the home to allow service users to be part of the planning, preparing and cooking of all meals.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	One service user was moved from this home at the start of 2019.	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management.	Ensure all risk assessments and risk register are updated to the new format as per the risk management policy.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit was completed at the start of 2019	Ensure all actions from IPC audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily fire checks completed. All PEEPs are fully updated and tested.	Delete duplicate PEEPs Ensure all staff have up to date fire safety awareness training,
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his	Each resident has had a self-administration of medication assessment completed in the past 12 months.	

or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	Not all PRNs had protocols in place.	Ensure all PRNs have an up to date protocol in place.
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff complete all core competencies including refreshers in the required timeframes.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Each service users SURA documents should be reviewed annually (or sooner if required)
7	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
8	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
9	Ensure all service users have an MDT meeting in 2019.
10	Ensure all service user have a completed OK Health Check in 2019.
11	Ensure all service user have a completed AMR in 2019
12	Ensure staff follow the organisational pathway for completing care plans.
13	Follow up on request for PBSPs to be reviewed by CNS in Behaviour and Psychology.
14	Not all staff in this area have received training on MAPA (refresher)
15	Number of Safeguarding plans are due for review or if no longer necessary closed off.
16	Staff members requires Children's first training
17	Ensure all service users receive monthly keyworker meetings in 2019
18	Ensure meaningful weekly service user meetings are taking place.
19	Advocacy initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.

20	Communication initial indicators need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
21	A review of PATH and goals would be helpful to ensure that all activities that take place are meaningful to the service users involved.
22	Ensure environmental audits take place monthly and that PIC follows up with all actions in a timely manner.
23	Continue to cook meals in the home to allow service users to be part of the planning, preparing and cooking of all meals
25	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019
26	A Critical Incident Review will be completed after every unplanned hospital admissions.
26	Ensure all risk assessments and risk register are updated to the new format as per the risk management policy.
27	Ensure all actions from IPC audit are followed up.
28	Delete duplicate PEEPs
29	Ensure all staff have up to date fire safety awareness training,
30	Ensure all PRNs have an up to date protocol in place.
31	Ensure all service user issues brought up in service users surveys are addressed.
32	Ensure all family issues brought up in friends and family surveys are addressed.

Designated Centre 17

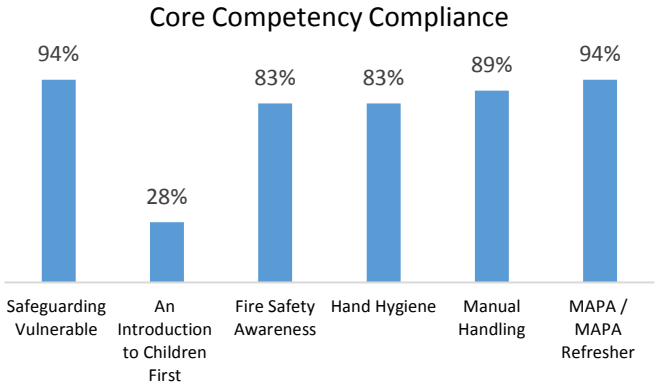
Location:	Bungalow 3, Bungalow 5
PIC:	Breege Byrne
Date of Publication:	April 2019

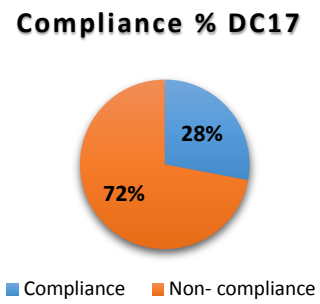
Service User Suggestions for Improvement – (Survey Results / Service User feedback)
Numerous requests were made to the Person in Charge to ask service users with the support form staff to complete the service users survey but unfortunately non were received back from this designated centre

Friends and Family Survey Feedback 2018

- (Family member) is well looked after, clean and always seems happy when we see them.
- Staff are very friendly and caring.
- (Family member) is much happier since moving into the bungalow and own room.
- Everything has improved over the past few years and is very good now.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge assigned to this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	Yes, there is no vacancies in this designated centre	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Bungalow 3** **Shift allocation as per 2019 DNA;** 1 .5 HCA Night Waking (Night staff split between B.3 + B.5)	

	1 SN 8-8.15pm 3 HCA 8-8.15pm **Bungalow 5** **Shift allocation as per 2019 DNA;** 1 .5 HCA Night Waking (Night staff split between B.3 + B.5) 1 SN 8-8.15pm 3 HCA 8-8.15pm	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies including refreshers in the required timeframes.

All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: Records	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. Personal supports plans is in place and up to date	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: Governance and Management	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly in this designated centre in 2018.	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
Regulation 30 Volunteers/Students	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 Notification of Incidents	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that were notifiable to HIQA were sent in within the correct timeframe in 2018.	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.

Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place.	Ensure complaints are spoken about at service user and staff meetings to ensure everyone is aware of how to correctly make and process a complaint.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Two resident did not have an MDT meeting in 2018	Ensure all service users have an MDT meeting in 2019.

Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check completed in the past 12 months.	Ensure all service user have a completed OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	2 service users have no evidence on SURA of receiving an AMR by a GP in 2018.	Ensure all service user have a completed AMR in 2019
Ensure there is care plans in place for each identified need.	Discrepancies exist between summary section of OK health Check, Initial Indicators and Current Care Plans. In some cases the number of conditions documented in the summary section of the Ok Health Check didn't match the number of care plans in place. Components not connecting.	Ensure staff follow the organisational pathway for completing care plans.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	Bungalow 3 One service user currently has an up to date behaviour support plan.	Not all staff in this area have received training on MAPA (refresher)
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A No restrictive practices at present.	
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**

Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	Bungalow 5 All safeguarding plans are due for review.	Number of Safeguarding plans are due for review or if no longer necessary closed off.
All staff must receive safeguarding and Children's First Training		Staff members requires Children's first training. Staff members require safeguarding training.
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	All residents have been receiving monthly keyworker meetings. Service user meetings were also taking place weekly these need to be reviewed to ensure they are meaningful	Ensure weekly service user meetings are meaningful and give direction and guidance for the week ahead.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding the needs of each service user in relation to advocacy these are reviewed annually.	
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have initial indicators that highlight the needs of each service user in relation to communicate these are reviewed annually	.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**

Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to the homes in this designated centre at any time. Staff will provide privacy to residents and visitors as required.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have full access to all their possessions at all times. Linen is laundered and returned to service users as soon as possible	
Each resident is supported to manage their own financial affairs.	All service users have staff support them with their finances.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	All staff speak respectably to all service users.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?		A review of PATH and goals would be helpful to ensure that all activities that take place are meaningful to the service users involved.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	Bungalow 3 Currently no family room/ private space for service users to receive visitors. Storage required as currently items are kept in the hall. Bungalow 5 Current office space as it is in resident's sitting room and infringes on their privacy, confidentiality and space.	

	Only one toilet in the house which is inaccessible when residents are being showered.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	Environmental audits are taking place monthly and PIC follows up with all actions in a timely manner. .	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Begin cooking meals in the home to allow service users to be part of the planning, preparing and cooking of all meals.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**

Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management.	Ensure all individual risk assessments are relevant.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit was completed at the start of 2019	Ensure all actions from IPC audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily fire checks completed. All PEEPs are fully updated and tested.	Ensure PEEPs state number of staff required in staff assistance section. Ensure all staff have up to date fire safety awareness training,

Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		Ensure all service users self-administration of medication assessments are reviewed annually.
There is up to date PRN protocols in place.	All PRNs had protocols in place.	
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff complete all core competencies including refreshers in the required timeframes.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Each service users SURA documents should be reviewed annually (or sooner if required)
7	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
8	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
	Ensure complaints are spoken about at service user and staff meetings to ensure everyone is aware of how to correctly make and process a complaint.

9	Ensure all service users have an MDT meeting in 2019.
10	Ensure all service user have a completed OK Health Check in 2019.
11	Ensure all service user have a completed AMR in 2019
12	Ensure staff follow the organisational pathway for completing care plans.
13	Follow up on request for PBSPs to be reviewed by CNS in Behaviour and Psychology.
14	Not all staff in this area have received training on MAPA (refresher)
15	Number of Safeguarding plans are due for review or if no longer necessary closed off.
16	Staff members requires Children's first training.
	Staff members require safeguarding training.
18	Ensure meaningful weekly service user meetings are taking place.
21	A review of PATH and goals would be helpful to ensure that all activities that take place are meaningful to the service users involved.
22	Begin cooking meals in the home to allow service users to be part of the planning, preparing and cooking of all meals.
25	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019
26	A Critical Incident Review will be completed after every unplanned hospital admissions.
26	Ensure all individual risk assessments are relevant.
27	Ensure all actions from IPC audit are followed up.
28	Ensure PEEPs state number of staff required in staff assistance section.
29	Ensure all staff have up to date fire safety awareness training,
30	Ensure all service users self-administration of medication assessments are reviewed annually.

Designated Centre 18

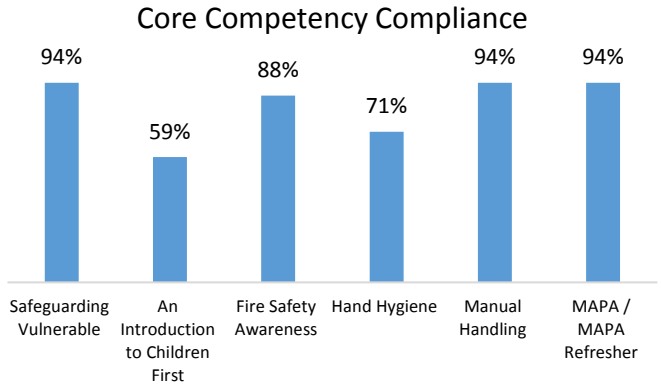
Location:	Woodlands 26, Woodlands 28
PIC:	Aine O'Reilly
Date of Publication:	April 2019

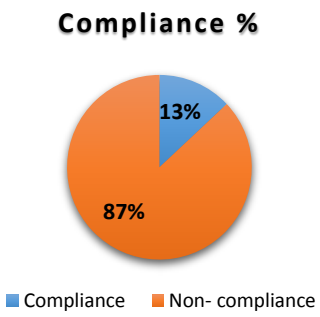
Service User Suggestions for Improvement – (Survey Results / Service User feedback)
No service user surveys were returned from this designated centre although numerous requests were made to the PIC.

Friends and Family Survey Feedback 2018

- We are kept well informed of (family members) well-being.
- Staff are always very helpful.
- The staff of Woodlands 28 do an excellent job in caring for (family member).
- (Family members) clothes at time can be soiled. I would like more attention given to this.
- There was a delay in putting up (family members) T.V

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge assigned to this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is no vacancies in this designated centre	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Woodlands 26** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking	

	0.5 RN Night Waking (W.26 and W. 28 share night nurse) 1 RN Day 8-8.15pm 3 HCA Day 8-8.15pm 0.5 Day Service **Woodlands 28** **Shift allocation as per 2019 DNA;** 1 HCA Night Waking 0.5 RN Night Waking (W.26 and W. 28 share night nurse) 1 RN Day 8-8.15pm 3 HCA Day 8-8.15pm 0.5 Day Service	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	Workforce planning system was not working during the time of the audit and printed rosters was not showing the correct staff that should be on duty so PIC has used a screenshot of the system rather than the roster.
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies including refreshers in the required timeframes.

All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly in this designated centre in 2018.	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**

Ensuring we report all HIQA notifiable incidents.	Most incidents that were notifiable to HIQA were sent in within the correct timeframe in 2018.	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	

Are all residents MDTs completed for 2018	One resident did not have an MDT meeting in 2018.	Ensure all service users have an MDT meeting in 2019.
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health Check completed in the past 12 months.	Ensure all service user have a completed OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	2 service users have no evidence on SURA of receiving an AMR by a GP in 2018.	Ensure all service user have a completed AMR in 2019
Ensure there is care plans in place for each identified need.	The number of issues identified in the OK Health Check does not complement the number of red initial indicators and care plans. There is no linkage between the three. Red initial indicators should only highlight chronic and acute conditions. All care plans should have titles	Ensure staff follow the organisational pathway for completing care plans.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	Woodlands 26 One service user currently has an up to date behaviour support plan.	Not all staff in this area have received training on MAPA (refresher)
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A No restrictive practices at present.	

Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	Woodlands 28 One safeguarding plan due for review.	One safeguarding plan due for review or if no longer necessary closed off.
All staff must receive safeguarding and Children's First Training		Staff members requires Children's first training. Staff members require safeguarding training.
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	All residents have been receiving monthly keyworker meetings. Service user meetings were also taking place weekly these.	
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy.	These need to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users communication initial indicators that detail the level of support needed when communication.	These need to be updated to ensure they highlight the needs of each service user in relation to communication, some have not been updated in a number of years.

Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to the homes in this designated centre at any time. Staff will provide privacy to residents and visitors as required.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have full access to all their possessions at all times. Linen is laundered and returned to service users as soon as possible	
Each resident is supported to manage their own financial affairs.	All service users have staff support them with their finances.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	All staff speak respectably to all service users.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?		A review of PATH and goals would be helpful to ensure that all activities that take place are meaningful to the service users involved.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the	Both homes are newly renovated and there is plenty of room for service users to circulate, bedrooms are personalised to the service users tastes.	

privacy, dignity and welfare of each person living there.		
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	Environmental audits are taking place monthly and PIC follows up with all actions in a timely manner. .	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Begin cooking meals in the home to allow service users to be part of the planning, preparing and cooking of all meals.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**

Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	These are two newly	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management. All risk assessments were updated to the new format.	
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit was completed in this designated centre	Ensure all actions from IPC audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily fire checks completed.	All PEEPs need to have YES or NO ticked on them so the fire evac plans are clear to all staff working in the home at any time. Ensure all fire drills are recorded on PEEPs.

Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		Ensure all service users self-administration of medication assessments are reviewed annually.
There is up to date PRN protocols in place.	All PRNs had protocols in place.	
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff complete all core competencies including refreshers in the required timeframes.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Each service users SURA documents should be reviewed annually (or sooner if required)
7	Ensure there is a schedule of staff meetings for 2019 to ensure they take place each month.
8	Ensure all incidents that are notifiable to HIQA are sent in within the correct timeframe in 2019.
9	Ensure all service users have an MDT meeting in 2019.
10	Ensure all service user have a completed OK Health Check in 2019.

11	Ensure all service user have a completed AMR in 2019
12	Ensure staff follow the organisational pathway for completing care plans.
14	Not all staff in this area have received training on MAPA (refresher)
15	Safeguarding plan due for review or if no longer necessary closed off.
	Advocacy initial indicators to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
	Communication initial indicators to be updated to ensure they highlight the needs of each service user in relation to advocacy, some have not been updated in a number of years.
16	Staff members requires Children's first training.
	Staff members require safeguarding training.
21	A review of PATH and goals would be helpful to ensure that all activities that take place are meaningful to the service users involved.
22	Begin cooking meals in the home to allow service users to be part of the planning, preparing and cooking of all meals.
25	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019
26	A Critical Incident Review will be completed after every unplanned hospital admissions.
26	Ensure all individual risk assessments are relevant.
27	Ensure all actions from IPC audit are followed up.
28	All PEEPs need to have YES or NO ticked on them so the fire evac plans are clear to all staff working in the home at any time.
29	Ensure all fire drills are recorded on PEEPs.
29	Ensure all staff have up to date fire safety awareness training,
30	Ensure all service users self-administration of medication assessments are reviewed annually.
31	Ensure family issues that were identified in family and friends survey are addressed.

Designated Centre 19

Location:	Woodlands 18
PIC:	Jeanybeth Rosarles
Date of Publication:	April 2019

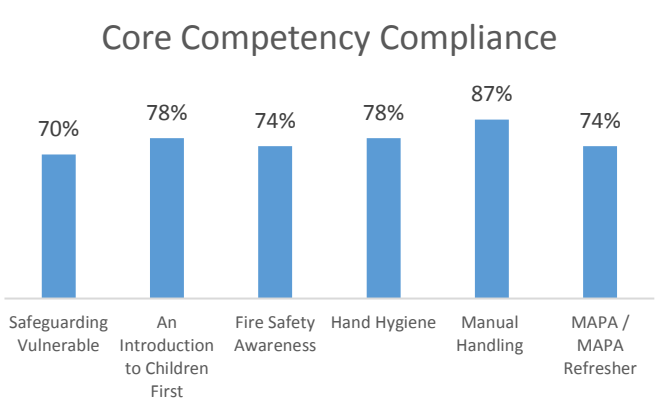
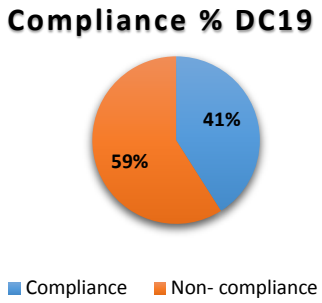
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- Garden needs to be updated to allow the service users to sit out in the good weather
- Would like more walks during the day.
- Would like to live with less people.
- Would like more bus drives.
- Due to shortages and irregular staff it is not always possible to go places.
- Would like multi-sensory sessions to start back up.
- Would like a bigger bedroom.
- Would like to be able to access money more easily.
- Would like more short breaks away.

Friends and Family Survey Feedback 2018

- I always find the care and support first class.
- It is a joy to visit Woodlands 18.
- (Family member) is more content and manageable when there is less staff changes.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	2.5 WTE vacancies in this designated centre.	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**The shift allocation based on 2019 DNA is;** 1 HCA Night Waking 1 RN Day 8-8.15pm 3 HCA Day 8-8.15pm	

	1 Day Service	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Staff Fire Safety training is out of date, ensure same is completed. Staff need to complete on site fire drill training. Ensure all staff complete, children's first training, hand hygiene, manual handling and MAPA training.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do.	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.

Personal supports plans is in place and up to date		
Regulation 23: Governance and Management	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were taking place monthly throughout 2018. PIC was using organisational template to ensure all relevant information was discussed.	
Regulation 30 Volunteers/Students	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 Notification of Incidents	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	All incidents that were notifiable to HIQA were notified within the correct timeframes.	
Regulation 32/33 Absence of the Person in Charge	**Findings**	**Comments and suggestions for improvement**
Person in Charge Knowing who to contact for support/decisions if the PIC is absent.	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 Complaints Procedure	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner Easy to read guidance and forms available to all Service Users	There is a complaints log in place and all complaints are processed in line with the policy.	

All complaints recorded on complaints log		

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	One resident did not have an MDT meeting in 2018	Ensure all residents have an MDT in 2019
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All residents had an OK Health Check in 2018	
Ensure each resident has had an Annual Medical Review completed by a GP.	One service user has no evidence on SURA of receiving an AMR by a GP in 2018.	Ensure all service users receive an AMR in 2019.
Ensure there is care plans in place for each identified need.	Care plans were not always fully completed. Some had review dates but there was no evidence that care plans had been reviewed. There was duplicate care plans in places. Red initial indicators do not guide to all relevant care plans. Some guide to needs sheets which are no longer used in this service	Ensure OK Health Checks, red initial indicators and care plans are in line with the organisational pathway.

Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	All service users have PBSPs in place. All staff are aware of these.	
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	Currently locked doors.	Number of practices in this home that need to be brought to the restrictive practice committee or discontinued.
Regulation 8 **Protection**	**Findings::**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is safeguarding plans in this home.	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**Findings:**	**Comments and suggestions for improvement**

Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Service user weekly meetings are taking place. Monthly keyworker meetings are taking place with all service users.	
All residents have access to advocacy services and information about their rights?	All service users have advocacy initial indicators on the SURA records that highlight the advocacy support they currently receive.	Ensure advocacy is discussed at service user meeting so all service users are aware of the services available to them.
Regulation 10 **Communication**	**Findings:**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication in initial indicators to help guide staff when communicating with each service user. These need to be reviewed annually to ensure they are effective and reflect the service users communication needs.	
Regulation 11 **Visits**	**Findings:**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to this designated centre. If requested staff will provide space and privacy to receive guests.	
Regulation 12 **Personal Possessions**	**Findings::**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have access to their own possessions at all times. Linen is laundered and returned to service users as soon as possible.	
Each resident is supported to manage their own financial affairs.	All service users receive support from staff with their finances.	

Regulation 13 **General Welfare & Development**	**Findings::**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Staff spoke respectably to all residents.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	Staff try to activate service users as much as possible but there is 8 ladies all who need support in the community.	A review of resident's goals and PATHs is necessary as meaningful activities were limited during audit. Ensure all staff are aware of in house activities that can take place when community activities are not taking place.
Regulation 17 **Premises**	**Findings::**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. **The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.**	Staff have worked to try to make house homely.	Main doors is too narrow so women in wheelchairs can only access the house through the back door.
Environmental Audit **Actions from environmental audits are completed in an effective manner.**		Ensure environmental audit takes place monthly. PIC to follow up on all actions from audit.
Regulation 18 **Food and Nutrition**	**Findings::**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Work on cooking in the home to provide greater choice to service users. This will also allow service user to become part of the planning, preparing and cooking of food
Regulation 20 **Information for Individuals**	**Findings::**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**Findings::**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is planned transitions from this home.	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**Findings::**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Ensure all risk assessments follow the ICC model. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**Findings::**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit was reviewed at the start of 2018.	Ensure all actions identified in the IPC audit have been followed up with.
Regulation 28 **Fire Precautions**	**Findings::**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	All PEEPs are reviewed and fully tested. Daily fire checks are taking place.	Some staff require fire safety awareness and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**Findings::**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and		Ensure all self-administration medication assessments are reviewed annually.

preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	All PRNS had up to date protocols in the Kardex folder	
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure all staff keep up to date with core competency training including refresher training.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Each service users SURA documents should be reviewed annually (or sooner if required).
7	Ensure all residents have an MDT in 2019
8	Ensure all service users receive an AMR in 2019.
9	Ensure OK Health Checks, red initial indicators and care plans are in line with the organisational pathway.
10	Number of practices in this home that need to be brought to the restrictive practice committee or discontinued.
11	Ensure all safeguarding plans are reviewed within the correct timeframes.
12	Staff members requires safeguarding training.
13	Staff members requires Children's first training.
14	Ensure advocacy is discussed at service user meeting so all service users are aware of the services available to them.
15	A review of resident's goals and PATHs is necessary as meaningful activities were limited during audit.
16	Ensure all staff are aware of in house activities that can take place when community activities are not taking place.
17	Have main doors are assessed as they are too narrow so women in wheelchairs can only access the house through the back door.
18	Ensure environmental audit takes place monthly and PIC to follow up on all actions from audit.
19	Work on cooking in the home to provide greater choice to service users.

20	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
21	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk.
22	Ensure all risk assessments follow the ICC model.
23	Ensure all actions identified in the IPC audit have been followed up with.
24	Some staff require fire safety awareness and on site fire drill training.
25	Ensure all self-administration medication assessments are reviewed annually.
26	Ensure all service user issues identified in the service users surveys are addressed.
27	Ensure all family issues identified in the family surveys are addressed.

Designated Centre 20

Location:	Bungalow 12
PIC:	Caoimhe Murphy
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- No surveys were filled in on behalf of service users all surveys had the exact same written under each question;
  Resident has limited communication methods and understanding and cannot answer these questions.

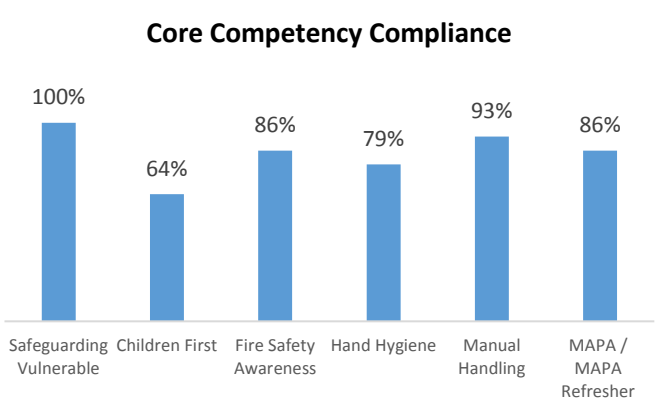
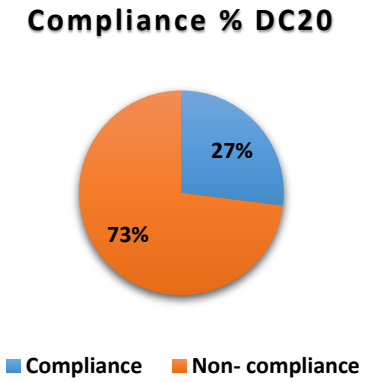
- These surveys are a tool that can be used to advocate on behalf of service users.
  In the future staff should look at using these surveys to highlight any areas in the service that could be improved with a view to improving the quality of life of the service users they know best.

Friends and Family Survey Feedback 2018

- The care (family member) receives is excellent.
- Staff know (family members) ways and can tell when he is not his usual self. This is especially important to us as a family as he cannot say when he is feeling unwell.
- Important that (family member) is cared for by kind compassionate people.
- We are happy with the bus trips and other activities which are being provided for (family member).
- (Family member) was brought to sister house for a birthday party. The family are forever grateful to everyone who organised this.
- Important to us that (family member) is safe, comfortable, gets attention and is kept occupied

- More staff is needed in the bungalow

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	The agreed complement of staff is currently working in this house.	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Staffing allocation as per 2019 DNA**; 1 HCA Night Waking 1 RN Day 3 HCA Day	

	1 Day Service	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competency training and refreshers and keep this training up to date as and when required
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive 4 effective supervisions in 2019.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**

Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA records should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly throughout 2018. PIC was using the agreed organisational template to ensure all key areas are discussed with all staff.	Ensure there is a schedule of meetings for 2019 so staff meetings take place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	All incidents that occurred in 2018 that were notifiable to HIQA were notified within the correct timeframe.	
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**

Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	2 service users did not have an MDT meeting in 2018	Ensure all service users receive an MDT meeting in 2019.
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users have had an OK health check completed in the past 12 months.	
Ensure each resident has had an Annual Medical Review completed by a GP.	1 service user has no record of receiving an AMR in 2018 on SURA.	Ensure all service users receive an AMR by a GP in 2019.
Ensure there is care plans in place for each identified need.	Care plans reviewed guide practice.	Ensure all care plans have a red initial indicator directing staff to the correct care plan.

		Ensure there is linkage between OK Health Check, Red initial indicators and care plans as per agreed organisational pathway.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	Currently 4 PBSP in place with input from Psychology	Ensure all staff are aware of the contents of service users PBSP. Ensure staff who require MAPA training complete same.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	There are locked external doors. These have been reviewed by the Restrictive Practice Committee throughout 2018 and there is a protocol in place.	Continue to trial removing restrictions in 2019
Regulation 8 **Protection**	**Findings:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is up to date safeguarding plans in this designated centre.	Ensure all staff are aware of safeguarding plans.
All staff must receive safeguarding and Children's First Training		Ensure staff members who require Children's first training complete same.

Regulation 9 **Residents rights**	**Findings:**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Weekly service user meetings are taking place.	Ensure all service users receive monthly keyworker meetings that are effective and provide guidance and direction for service user's meaningful activities.
All residents have access to advocacy services and information about their rights?	All service users have up to date initial indicators regarding advocacy and the information that is available to them.	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights. Ensure all keyworkers are aware of how to advocate on behalf of service users who have limited communication.
Regulation 10 **Communication**	**Findings:**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	Each service user has a communications section in their personal support plan that is updated annually.	
Regulation 11 **Visits**	**Findings:**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	There is a sunroom, sitting room and multi-sensory room available to all service users where they can meet their families if they wish. All families are welcome to visit Woodlands 20 whenever they like.	
Regulation 12 **Personal Possessions**	**Findings:**	**Comments and suggestions for improvement**

Each resident has access to and retains control of personal property and possessions.	All residents have control over their own clothes which are kept in their own rooms. All linens are laundered regularly and returned to the resident.	
Each resident is supported to manage their own financial affairs.	All residents receive support from staff with their finances.	
Regulation 13 **General Welfare & Development**	**Findings:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Staff were viewed to be spoke respectably to service users.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	All service users sitting around in the sun room or sitting room.	This could be improved. No meaningful activities taking place in the house on the day of the audit. Ensure staff are aware that meaningful activities can take place inside the home as well as outside. A review of service users PATH/ goals needs to take place to ensure there is better direction for activities that take place.
Regulation 17 **Premises**	**Findings:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	Evidence that staff have tried very hard to make the bungalow more homely. All service users had salt lamps and aroma diffusers to help with the calmness.	There is adequate personal space during the day- sitting room, day room, dining room, multi-sensory room, however some men's rooms are very small and cramped.
Environmental Audit	Environmental audits had not been taking place monthly.	PIC to ensure environmental; audits are completed monthly and all actions are followed up.

Actions from environmental audits are completed in an effective manner.		
Regulation 18 **Food and Nutrition**	**Findings:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Work on cooking in the home to improve the meals/ meal choices provided to service users. This will also allow service users to become part of the planning, preparing and cooking stages.
Regulation 20 **Information for Individuals**	**Findings:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**Findings:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk.

Regulation 26 **Risk Management**	**Findings:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Ensure all risk assessments are completed in the new format and follow the ICC model is followed to ensure clear identification of risk and clarity on cause and context on all risk assessments. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**Findings:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	An infection prevention and control audit took place in this home.	PIC to follow up on all action identified by the CNS in IPC
Regulation 28 **Fire Precautions**	**Findings:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	All PEEPs are up to date and tested Daily fire checks are happening in the home. All staff asked were able to explain the fire evacuation procedure for the home.	Ensure all staff are up to date with fire safety awareness training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**Findings:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take	All residents have completed a self-administration medication assessment in the last 12 months.	

responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	All PRNs had protocols in place	
SAMs trained staff have in date SAMs training,	N?A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Staff to be aware of how to fill in service user surveys on behalf of service users in order to make suggestions that may improve their quality of life.
2	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
3	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Ensure staff complete all core competency training and refreshers and keep this training up to date as and when required
6	It is important that all staff receive 4 effective supervisions in 2019.
7	Each service users SURA records should be reviewed annually (or sooner if required)
8	Ensure there is a schedule of meetings for 2019 so staff meetings take place monthly.
9	Ensure all service users receive an MDT meeting in 2019.
10	Ensure all service users receive an AMR by a GP in 2019.
11	Ensure all care plans have a red initial indicator directing staff to the correct care plan
12	Ensure there is linkage between OK Health Check, Red initial indicators and care plans as per agreed organisational pathway.
13	Ensure all staff are aware of the contents of service users PBSP.
14	Ensure staff who require MAPA training complete same.
15	Continue to trial removing restrictions in 2019
16	Ensure all staff are aware of safeguarding plans.

17	Ensure staff members who require Children's first training complete same.
18	Ensure all service users receive monthly keyworker meetings that are effective and provide guidance and direction for service user's meaningful activities.
19	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
20	Ensure all keyworkers are aware of how to advocate on behalf of service users who have limited communication.
21	Ensure staff are aware that meaningful activities can take place inside the home as well as outside.
22	A review of service users PATH/ goals needs to take place to ensure there is better direction for activities that take place
23	PIC to ensure environmental; audits are completed monthly and all actions are followed up.
24	Work on cooking in the home to improve the meals/ meal choices provided to service users.
25	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
26	A Critical Incident Review will be completed after every unplanned hospital admissions
27	Ensure all risk assessments are completed in the new format
28	Ensure all staff are up to date with fire safety awareness training and on site fire drill training
29	Ensure all service user issues identified in the service users surveys are addressed.
30	Ensure all family issues identified in the family surveys are addressed.

Designated Centre 21

Location:	Bungalow 10
PIC:	Oluwakorede Ogunleye
Date of Publication:	April 2019

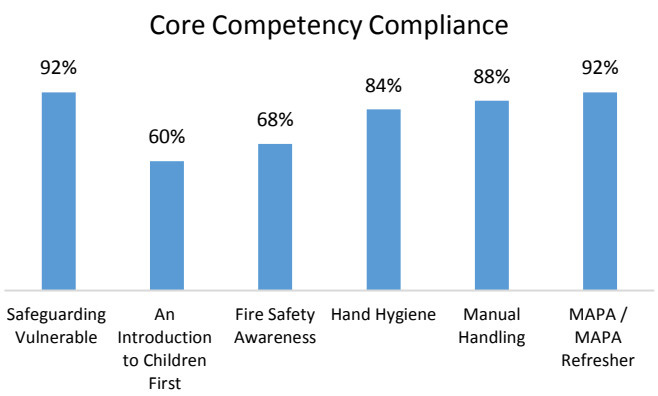
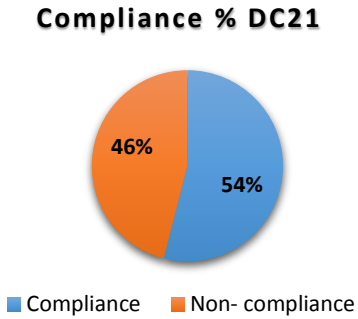
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- Bedroom is very small
- Would like more food choices.
- Would like more outings.
- Would like to mix in the community more.
- Would like to start swimming.
- Would like more bus drives

Friends and Family Survey Feedback 2018

- Important to me that (family member) is being looked after so well and is getting the best care and attention by the management and staff in Stewarts.
- My mind is at ease knowing that I can visit (family member) at any time or phone to see how they are getting on.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	The agreed complement of staff is currently working in this house.	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Staffing allocation as per 2019 DNA**; 1 HCA Night Waking 1 RN Day 8-8.15pm 4HCA Day 8- 8.15pm	

	0.6 Day Service	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competency training and refreshers and keep this training up to date as and when required
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive 4 effective supervisions in 2019.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do.	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA records should be reviewed annually (or sooner if required) in

Personal supports plans is in place and up to date		order to ensure information is correct and relevant.
Regulation 23: Governance and Management	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were taking place monthly throughout 2018. PIC was using the agreed organisational template to ensure all key areas are discussed with all staff.	Ensure minutes are typed so all staff can read and follow.
Regulation 30 Volunteers/Students	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 Notification of Incidents	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that occurred in 2018 that were notifiable to HIQA were notified within the correct timeframe.	Ensure all notifiable incidents are sent to HIQA within the correct timeframes in 2019.
Regulation 32/33 Absence of the Person in Charge	**Findings**	**Comments and suggestions for improvement**
Person in Charge Knowing who to contact for support/decisions if the PIC is absent.	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 Complaints Procedure	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner	There is a complaints log in place and all complaints are processed in line with the policy.	

Easy to read guidance and forms available to all Service Users **All complaints recorded on complaints log**		

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	All service users had an MDT meeting in 2018	Ensure all service users receive an MDT meeting in 2019.
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users have had an OK health check completed in 2018.	Ensure all service users receive an OK Health Check in 2019.
Ensure each resident has had an Annual Medical Review completed by a GP.	All service users received an AMR in 2018 by a GP.	Ensure all service users receive an AMR by a GP in 2019.
Ensure there is care plans in place for each identified need.	Review all OK health checks, red initial indicators and health care plans as they are not inline. The information differs between the 3. Needs sheets are obsolete in the service and need to be deactivated.	Ensure all care plans have a red initial indicator directing staff to the correct care plan. Ensure there is linkage between OK Health Check, Red initial indicators and care plans as per agreed organisational pathway.

Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	5 PBSP out of date (put in place in 2016) all reviewed in July 2018, awaiting feedback from Psychology.	Follow up on requests for updated PBSPs Ensure staff who require MAPA training complete same.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	3 restrictive practices in place. These have been reviewed by the Restrictive Practice Committee throughout 2018 and there is a protocol in place.	Continue to trial removing restrictions in 2019
Regulation 8 **Protection**	**Findings:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	All safeguarding plans need to be reviewed.	Ensure all staff are aware of safeguarding plans and ensure all safeguarding plans are reviewed or if no longer necessary closed off.
All staff must receive safeguarding and Children's First Training		Ensure staff members who require Children's first training and Safeguarding training complete same.
Regulation 9 **Residents rights**	**Findings:**	**Comments and suggestions for improvement**

Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all service users are receiving monthly key worker meetings. Weekly service user meetings are taking place.	Ensure all service users receive monthly keyworker meetings that are effective and provide guidance and direction for service user's meaningful activities.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy and the information that is available to them.	Ensure initial indicators are reviewed annually as some have not been updated in a number of years. Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights. Ensure all keyworkers are aware of how to advocate on behalf of service users who have limited communication.
Regulation 10 **Communication**	**Findings:**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	Each service user has a communications section in their personal support plan that is updated annually.	
Regulation 11 **Visits**	**Findings:**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	There is a sunroom, sitting room and dining room available to all service users where they can meet their families if they wish. All families are welcome to visit whenever they like.	
Regulation 12 **Personal Possessions**	**Findings:**	**Comments and suggestions for improvement**

Each resident has access to and retains control of personal property and possessions.	All residents have control over their own clothes which are kept in their own rooms. All linens are laundered regularly and returned to the resident.	
Each resident is supported to manage their own financial affairs.	All residents receive staff support to manage finances	
Regulation 13 **General Welfare & Development**	**Findings:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Staff were viewed to be offering choice to service users during meal times.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	Most service users sitting in the day room. 1 was gone horseriding 1 was in bed during the last audit.	This could be improved. No meaningful activities taking place in the house on the day of the audit. Ensure staff are aware that meaningful activities can take place inside the home as well as outside. A review of service users PATH/ goals needs to take place to ensure there is better direction for activities that take place.
Regulation 17 **Premises**	**Findings:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	Work could be done to improve the overall appearance of this bungalow for residents and bedrooms are quite small.	The ceiling outside bedroom 1 and the bathroom is cracked and staff stated that it often leaks.
Environmental Audit	Environmental audits were taking place monthly.	PIC to ensure environmental; audits are completed monthly and all actions are followed up.

Actions from environmental audits are completed in an effective manner.		
Regulation 18 **Food and Nutrition**	**Findings:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Work on cooking in the home to improve the meals/ meal choices provided to service users. This will also allow service users to become part of the planning, preparing and cooking stages.
Regulation 20 **Information for Individuals**	**Findings:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**Findings:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk.

Regulation 26 **Risk Management**	**Findings:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Ensure all risk assessments are completed in the new format and follow the ICC model is followed to ensure clear identification of risk and clarity on cause and context on all risk assessments. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**Findings:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	An infection prevention and control audit took place in this home.	PIC to follow up on all action identified by the CNS in IPC
Regulation 28 **Fire Precautions**	**Findings:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	All PEEPs are up to date and tested Daily fire checks are happening in the home. All staff asked were able to explain the fire evacuation procedure for the home.	Ensure all staff are up to date with fire safety awareness training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**Findings:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take		All residents must have completed a self-administration medication assessment in the last 12 months.

responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	All PRNs had protocols in place	
SAMs trained staff have in date SAMs training,	Yes	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Staff to be aware of how to fill in service user surveys on behalf of service users in order to make suggestions that may improve their quality of life.
2	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
3	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Ensure staff complete all core competency training and refreshers and keep this training up to date as and when required
6	It is important that all staff receive 4 effective supervisions in 2019.
7	Each service users SURA records should be reviewed annually (or sooner if required)
8	Ensure all staff meeting minutes are typed.
9	Ensure all notifiable incidents are sent to HIQA within the correct timeframes in 2019.
10	Ensure all service users receive an MDT meeting in 2019.
11	Ensure all service users receive an OK Health Check in 2019.
12	Ensure all service users receive an AMR by a GP in 2019.
13	Ensure all care plans have a red initial indicator directing staff to the correct care plan
14	Ensure there is linkage between OK Health Check, Red initial indicators and care plans as per agreed organisational pathway.
15	Follow up on requests for updated PBSPs from Psychology.
16	Ensure staff who require MAPA training complete same.

17	Continue to trial removing restrictions in 2019
18	Ensure all staff are aware of safeguarding plans.
19	Ensure all safeguarding plans are reviewed or if no longer necessary closed off.
20	Ensure staff members who require Children's first training complete same.
21	Ensure all service users receive monthly keyworker meetings that are effective and provide guidance and direction for service user's meaningful activities.
22	Ensure initial indicators are reviewed annually as some have not been updated in a number of years.
23	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
24	Ensure all keyworkers are aware of how to advocate on behalf of service users who have limited communication.
25	Ensure staff are aware that meaningful activities can take place inside the home as well as outside.
26	A review of service users PATH/ goals needs to take place to ensure there is better direction for activities that take place
27	PIC to ensure environmental; audits are completed monthly and all actions are followed up.
28	Work on cooking in the home to improve the meals/ meal choices provided to service users.
29	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
30	A Critical Incident Review will be completed after every unplanned hospital admissions
31	Ensure all risk assessments are completed in the new format
32	Ensure all staff are up to date with fire safety awareness training and on site fire drill training
33	All residents must have completed a self-administration medication assessment in the last 12 months.
34	Ensure all service user issues identified in the service users surveys are addressed.

Designated Centre 22

Location:	House 17, Aisling House
PIC:	Aidan Farrell
Date of Publication:	April 2019

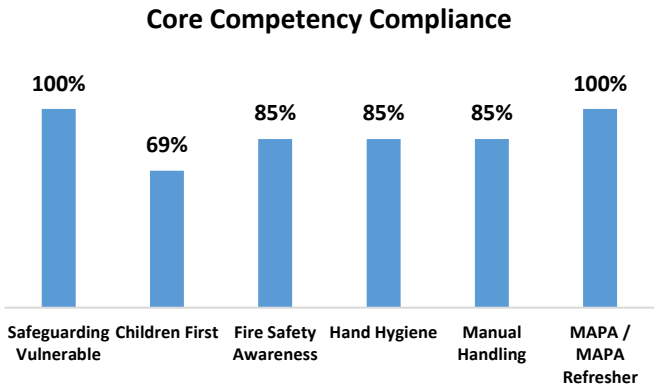
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

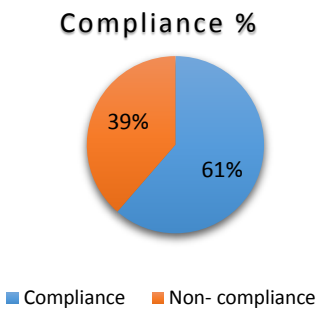
- Both service users would like the footpath extended from the orchard to Aisling House
- Would like more access to transport
- Not happy that house 17 was left with no day activation staff for 5 months
- Enjoy having more regular staff
- Would like to live in a house with less people
- Would like a double bed
- Really enjoy home cooked meals including watching and helping make them
- Would like more community activities
- Would like a separate family room
- Would like a bath in the house.

Friends and Family Survey Feedback 2018

- Very satisfied with all areas of care provided to (family member)
- Staff are always very nice nothing is too much trouble for them. I can ask them anything.
- Important that (family member) is happy and well cared for.
- Very satisfied with the support and care (family member) is receiving through the kindness of staff in this house
- A chair lift would be helpful for (family member) whose mobility has diminished.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	The agreed complement of staff is currently working in both houses but agency staff are being used to fill core vacancies.	Current designated centre vacancies is 2 HCA
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	There is a significant number of agency staff used in House 17 that can impact on the service users continuity of care.	

	PIC tries to ensure when possible regular agency staff and relief staff are used. **<u>House 17</u>** **Agreed staffing allocation per shift**; 2 HCA Night Waking (1 is 1:1) 1 RN Day 8-8.15pm 5 HCA Day 8-8.15pm (1 is 1:1) 1 Day Service **<u>Aisling House</u>** **Agreed staffing allocation per shift;** 2 HCA Night Waking 4 Staff per day (All HCA except for 1 SN line currently CNM1)	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies and keep this training up to date as and when required

All staff will receive quarterly supervisions from their line manager		It is important that all staff receive 4 effective supervisions in 2019.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were taking place monthly throughout 2018. PIC was using the agreed organisational template to ensure all key areas are discussed with all staff.	
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**

Ensuring we report all HIQA notifiable incidents.	All incidents that occurred in 2018 that were notifiable to HIQA were notified within the correct timeframe.	
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	

Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service user had an OK Health Check completed in 2018 by a Nurse.	
Ensure each resident has had an Annual Medical Review completed by a GP.	All service user had an AMR completed in 2018 by a GP.	
Ensure there is care plans in place for each identified need.	All residents have health care plans in place that guide practice.	
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	**House 17** PBSP are reviewed by Psychology 4 are in date, Psychology have requested information for 2 residents, referral was sent for a review of one service users PBSP. **Aisling House** PBSP are due for review by the CNS in Behaviour. All staff are aware of PBSP in place and the recommended control measures.	PIC to ensure Psychology get the information required. Follow up on request for review of one service users plan. A number of staff require up to date MAPA training.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	House 17 Helmet was discontinued by CNS in Behaviour and transferred to PBSP. This was monitored through a restraints log. Locked front door is still in place. Aisling. Locked internal and external door. Shower controls. Bodysuit/ Sleepsuit	PIC is looking into alternatives to make the locked door less restrictive for all other services users. Continue to trial removing restrictions throughout 2019

Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is up to date safeguarding plans in House 17 that have clear detailed reviews. There is no open safeguarding plans in Aisling House.	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Weekly service user meetings are taking place in both homes. In House 17 some service users were missing keyworker meetings on SURA.	Ensure all service users receive monthly keyworker meetings.
All residents have access to advocacy services and information about their rights?	3 residents in House 17 have had referrals made to the national advocacy services The residents in Aisling House do not access advocacy services. Both have very good family involvement who advocate regularly on their behalf.	
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**

All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication initial indicators that detail the level of support needed when communication. This is reviewed annually.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in both homes at any time.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have control over their own clothes which are kept in their own rooms. All linens are laundered regularly and returned to the resident.	
Each resident is supported to manage their own financial affairs.	Residents are supported by staff with their finances.	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents in both homes are treated with dignity and respect by all staff.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	In House 17 The PIC has implemented a very comprehensive meaningful activities tracker that links to a drop in incidents and safeguarding issues. In Aisling House One resident will decide on a daily basis what he would like to do for the day. It can sometimes deviate from the personal plan. He is	

	facilitated to engage in whatever activity he chooses on the day. Both residents have a meaningful day, lots of activities and outings are happening	
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.		House 17 hygiene and household cleaning requires attention as PIC does not feel it is up to standard. Aisling house requires redecoration and reorganisation. Hygiene standards require attention and monitoring. The upstairs area has been closed off for use.
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Staff are cooking meals in House 17 which allows service users to be involved in the planning and cooking of meals which service users expressed in their surveys to really enjoy.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**

A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	3 Service users are due to move from House 17 in 2019 1 service user has already transferred to a more suitable accommodation on campus. The transition toolkits and business case submissions are currently being developed for 2 service users.	A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff. All risk assessments have been updated to the new format.	Ensure the Risk Category Section on all risk assessments is completed in line with the HSE National Policy, e.g. Harm to a Person. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit was completed at the start of 2018.	Ensure all actions identified from the IPC audit are followed up with.

Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly. Staff are trained in fire drills and staff training in evacuation procedures.	Daily checks are completed.	Ensure PEEPs are reviewed before they go past review dates. A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		Each resident needs to have a self-administration of medication assessment that is reviewed every 12 months.
There is up to date PRN protocols in place.	All PRN protocols are up to date and available in the kardex folder in the home	
SAMs trained staff have in date SAMs training,	Staff have only recently completed SAMs training	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure current designated centre vacancies are filled to prevent the use of agency staff.
5	Ensure staff complete all core competencies and keep this training up to date as and when required
6	It is important that all staff receive 4 effective supervisions in 2019.
7	Each service users SURA documents should be reviewed annually (or sooner if required).
8	PIC to ensure Psychology get the information required regarding PBSPs for 2 service users
9	Follow up on request for review of one service users PBSP.
10	Ensure all staff have up to date MAPA training.
11	Continue to trial removing restrictions throughout 2019
12	Ensure all safeguarding plans are reviewed within the correct timeframes.
13	Ensure staff members who require safeguarding training complete same.
14	Ensure staff members who require Children's first training complete same.
15	Ensure all service users receive monthly keyworker meetings.
16	House 17 hygiene and household cleaning requires attention as PIC does not feel it is up to standard.
17	Aisling house requires redecoration and reorganisation. Hygiene standards require attention and monitoring.
18	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
19	A Critical Incident Review will be completed after every unplanned hospital admission.
20	Ensure the Risk Category Section on all risk assessments is completed in line with the HSE National Policy.
21	Ensure all actions identified from the IPC audit are followed up with.
22	Ensure PEEPs are reviewed before they go past review dates.
23	A number of staff require fire safety training and on site fire drill training
24	Each resident needs to have a self-administration of medication assessment that is reviewed every 12 months
25	Follow up with technical service regarding the assessment of a pathway outside Aisling House
26	Follow up on request from a service user to have a double bed.
27	Request that house is assessed to include a bath as per service user's request.
28	Facilitate more community activities for service users who request same.
29	Follow up on family request for a chair lift for service user whose mobility has declined.

Designated Centre 23

Location:	Bungalow 13
PIC:	Chengeto Jeyacheya
Date of Publication:	April 2019

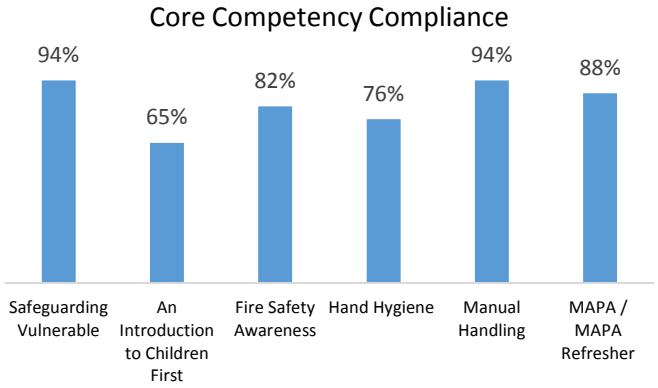
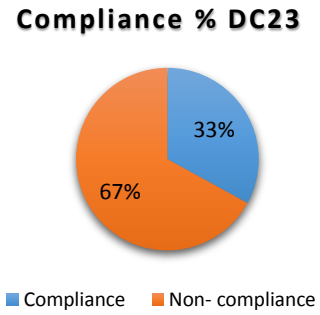
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- I would like to visit the sensory garden more.
- Would like more storage space in bedroom.
- Would love to see my family more.

Friends and Family Survey Feedback 2018

- (Family member) is very well looked after in Bungalow 13.
- Staff are very nice and helpful.
- It is important to us that there is good communication between my family and staff.
- Always made to feel welcome when we visit.
- Would like (family member) to receive a power pack for his wheelchair.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	The agreed complement of staff is currently working in this house.	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Agreed staffing allocation per shift as per 2019 DNA**; 1 HCA Night Waking 1 RN Day 8-8.15pm	

	3 HCA Day 8-8.15pm .38 Day Service (Query 1)	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies and keep this training up to date as and when required
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive 4 effective supervisions in 2019.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**

Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were taking place monthly throughout 2018. PIC was using the agreed organisational template to ensure all key areas are discussed with all staff.	
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that occurred in 2018 that were notifiable to HIQA were notified within the correct timeframe.	Ensure all notifiable incidents are reported in the correct timeframe in 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**

Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all residents had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service user had an OK Health Check completed in in the past 12 months.	Ensure all service users have an OK Health Check completed in 2019
Ensure each resident has had an Annual Medical Review completed by a GP.	2 service users have no evidence of having had an AMR completed in 2018 by a GP.	Ensure all service users have an AMR completed by a GP in 2019
Ensure there is care plans in place for each identified need.	Red initial indicators do not always guide to relevant care plans.	PIC to ensure all staff are following the agreed organisational pathway for creating health care plans.

	Review care plans to ensure they are all necessary.	
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	2 residents have PBSPs completed by Psychology. 2 referred and still waiting input.	Follow up on referral for two residents to be seen by psychology. A number of staff require up to date MAPA training.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A all restrictions have been discontinued in this house.	
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is up to date safeguarding plans in this designated centre.	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training

Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all service users were receiving monthly keyworker meetings in 2018. Service users weekly meetings are taking place but these need to be reviewed as they are generic and the same thing is written every week.	Ensure all service users receive monthly keyworker meetings. Ensure service users meetings are meaningful and provide guidance and direction for the week ahead.
All residents have access to advocacy services and information about their rights?	All service users have up to date advocacy initial indicators that detail the level of support needed with advocacy. This is reviewed annually.	
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication initial indicators that detail the level of support needed when communicating. This is reviewed annually.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in this home at any time.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have control over their own clothes which are kept in their own rooms. All linens are laundered regularly and returned to the resident.	
Each resident is supported to manage their own financial affairs.	All residents receive support from staff with their finances.	

Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents are treated with dignity and respect by all staff.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?		Review of PATH and goals required to ensure that meaningful activities are taking place and also to educate staff that meaningful activities can also take place within the home.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. **The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.**	There is minor decorative repairs required in this designated centre that the PIC is following up with regularly.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Begin to cook meals in this designated centre to allow service users to be involved in the planning and cooking of meals.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Ensure all risk assessments have been amended to new format as per risk management policy. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	An IPC audit is due in this home.	
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily checks are completed. PEEPs are fully completed and tested. Ensure all fire drills are recorded on PEEPs	A number of staff require fire safety training and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his	Each resident had a self-administration of medication assessment that is reviewed every 12 months.	

or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.		Ensure all PRN protocols are up to date
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure current designated centre vacancies are filled to prevent the use of agency staff.
5	Ensure staff complete all core competencies and keep this training up to date as and when required
6	It is important that all staff receive 4 effective supervisions in 2019.
7	Each service users SURA documents should be reviewed annually (or sooner if required).
8	Ensure all notifiable incidents are reported in the correct timeframe in 2019.
9	Ensure all service users have an OK Health Check completed in 2019
10	Ensure all service users have an AMR completed by a GP in 2019
11	PIC to ensure all staff are following the agreed organisational pathway for creating health care plans.
12	Follow up on referral for two residents to be seen by psychology.
13	Ensure all staff have up to date MAPA training.
14	Continue to trial removing restrictions throughout 2019
15	Ensure all safeguarding plans are reviewed within the correct timeframes.
16	Ensure staff members who require safeguarding training complete same.
17	Ensure staff members who require Children's first training complete same.
18	Ensure all service users receive monthly keyworker meetings.
19	Ensure service users meetings are meaningful and provide guidance and direction for the week ahead.

20	All service users have up to date communication initial indicators that detail the level of support needed when communication. This is reviewed annually.
21	Begin to cook meals in this designated centre to allow service users to be involved in the planning and cooking of meals.
22	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
23	A Critical Incident Review will be completed after every unplanned hospital admission.
24	Ensure all risk assessments have been amended to new format as per risk management policy.
25	A number of staff require fire safety training and on site fire drill training
26	Ensure all PRN protocols are up to date
27	Ensure all service user issues identified in service users surveys are addressed.
28	Ensure all family issues identified in family surveys are addressed.

Designated Centre 24

Location:	Stepping Stones 1, Stepping Stones 2, Stepping Stones 3, Stepping Stones 4
PIC:	Peter Corrigan
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

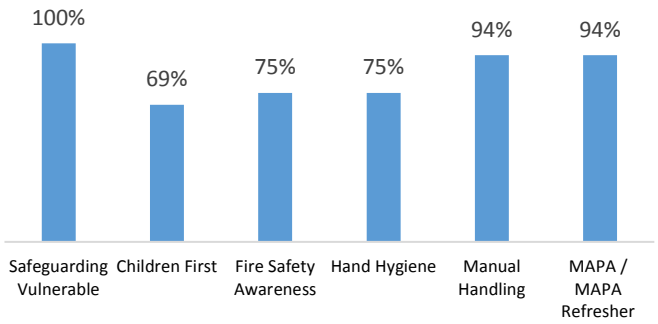
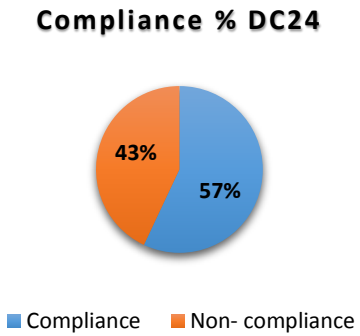
- Would like a washing machine and dryer in the apartment.
- Would like to do more art and craft.
- Would like more long bus drives and more dining out.
- Would like to have regular staff more consistently.
- Would like my own garden.
- Would like a day service or a place to work.
- Would like to do more activities in the community.

Friends and Family Survey Feedback 2018

- The use of agency staff concerns me because it takes time for (family member) to get to know them.
- The grounds on campus are well kept and have a relaxing and calming effect on mental health.
- Daily activities are limited for (family member) and so is contact with people her own age.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house staff have not signed to say they have read each one in all homes.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced. Ensure staff sign to say they have read all policies
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is 2.3 WTE vacancy in this designated centre	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**<u>Stepping Stones 1</u>** **Proposed staffing allocation per shift based on 2019 DNA**; 1 HCA Night Waking 2 HCA Day 8-8.15pm **<u>Stepping Stones 2</u>** **Proposed staffing allocation per shift based on 2019 DNA**; 1 HCA Night Waking 2 HCA Day 8-8.15pm **<u>Stepping Stones 3</u>** **Proposed staffing allocation per shift based on 2019 DNA**; 1 HCA Night Waking 1 HCA Day 8-8.15pm **<u>Stepping Stones 4</u>** **Proposed staffing allocation per shift based on 2019 DNA**; 1 HCA Night Waking 1 HCA Day 8-8.15pm (Is 2:1 for community inclusion)	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	

Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Staff need to ensure all core competency training is kept up to date including refresher training.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**

Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings are taking place monthly however the minutes are not always being placed in the correct folder in each home.	Ensure all meetings minutes are placed in the correct folder.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that required a HIQA notification were completed within the correct timeframes in 2018.	Ensure all incidents that require a HIQA notification in 2019 are completed within the correct timeframes.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health check in 2018	Ensure all OK Health Checks are completed in 2019 and are reviewed by a nurse.
Ensure each resident has had an Annual Medical Review completed by a GP.	There is no evidence of 2 service users in this DC receiving an AMR in 2018.	Ensure all service users receive an AMR in 2019 by a GP.
Ensure there is care plans in place for each identified need.	Ensure all care plans have titles and enough details to guide practice. Ensure all care plans are identified in the red initial indicators.	Ensure OK Health Check, red initial indicators and care plans link as per the agreed organisational pathway.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**

Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	Interim PBSP in place since July 2018. Psychology begun an assessment in Feb 2019. One service user is awaiting further input from Psychology. No review since 2017 and this was in relation to a previous residence. One service users PBSP is out of date was due to be reviewed in December 2018 All staff were aware of the controls recommended in PBSP.	Follow up on referrals for PBSP reviews and updates.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	SS2: Locked back gate so service user can access the garden when he likes. SS3: Locked door only when necessary. SS4: Locked door	Continue to trial removing restrictions in 2019. Ensure all restrictions are reviewed by the restrictive practice committee within the correct timeframes.
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is a safeguarding plan in this designated centre.	Ensure all safeguarding plans are reviewed within the correct timeframes and if no longer relevant closed off.

All staff must receive safeguarding and Children's First Training		Staff members require Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Residents are not having regular monthly keyworker meetings. Service user weekly meetings are taking place in most homes in this designated centre weekly.	Ensure weekly service user meetings take place in all homes.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy and the information that is available to them.	Ensure advocacy initial indicators are reviewed annually as some have not been reviewed in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	Each service user has a communications section in their personal support plan that highlights communicating supports relevant to each person.	Ensure communication initial indicators are reviewed annually as some have not been reviewed in a number of years.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome to all homes in the designated centre. Staff will support service users to meet families in privacy if they wish.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have access to their own possessions and clothes are kept in their own wardrobes in their room.	

	All linens are laundered regularly and returned to service users.	
Each resident is supported to manage their own financial affairs.	All residents are supported by staff to manage their finances	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	All residents are treated with dignity and respect.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	Each day is led by the service user in each apartment.	Ensure a review of PATH and goals are completed to ensure all activities are in line with service users' needs and wishes.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. **The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.**	Staff have worked to make each apartment homely, however the apartments are quite institutional in appearance**.** There is a number of small maintenance issues required that the PIC is following up on,	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	Environmental audits were taking place monthly in all homes. All actions were being followed up and completed by the PIC	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	All meals are cooked in the home by staff. Service users take part in the planning, preparing and cooking stages where possible.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Ensure risk assessments have been updated to the new format and that the ICC model is followed to ensure clear identification of risk and clarity on cause and context on all risk assessments. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	All PEEPs are reviewed and fully tested.	Staff require fire safety awareness training and on site fire drill training.
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with	2 Self-administration assessments were not completed in the past 12 months.	Ensure all service users have a self-administration of medication assessment completed within the last 12 months.

his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	There was up to date protocols for all PRNs.	
SAMs trained staff have in date SAMs training,	All SAMs trained staff have in date training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure staff sign to say they have read all policies
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Staff need to ensure all core competency training is kept up to date including refresher training.
6	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
7	Each service users SURA documents should be reviewed annually (or sooner if required).
8	Ensure all staff meetings minutes are placed in the correct folder.
9	Ensure all notifiable incidents are sent to HIQA within the correct timeframes.
10	Ensure all OK Health Checks are completed in 2019 and are reviewed by a nurse.
11	Ensure all service users receive an AMR in 2019 by a GP.
12	Ensure OK Health Check, red initial indicators and care plans link as per the agreed organisational pathway.
13	Follow up on referrals for PBSP reviews and updates.
14	Ensure no restrictions are put in place without being put to the restrictive practice committee.
15	Continue to trial removing restrictions in 2019. Ensure all restrictions are reviewed by the restrictive practice committee within the correct timeframes.
16	Ensure all safeguarding plans are reviewed within the correct timeframes and if no longer relevant closed off.
17	Ensure weekly service user meetings take place in all homes.

18	Ensure advocacy initial indicators are reviewed annually as some have not been reviewed in a number of years.
19	Ensure communication initial indicators are reviewed annually as some have not been reviewed in a number of years.
20	Ensure a review of PATH and goals are completed to ensure all activities are in line with service users' needs and wishes.
21	Ensure environmental audit takes place monthly in each home.
22	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
23	A Critical Incident Review will be completed after every unplanned hospital admissions.
24	Ensure risk assessments have been updated to the new format and that the ICC model is followed to ensure clear identification of risk and clarity on cause and context on all risk assessments.
25	PIC to ensure all actions to come from IPC audit are followed up.
26	Ensure all service users have a self-administration of medication assessment completed within the last 12 months.
27	Ensure all service user issues identified in service users surveys are addressed.
28	Ensure all family issues identified in family surveys are addressed.

Designated Centre 25

Location:	Woodlands 20
PIC:	Aedin Felming Brooks
Date of Publication:	April 2019

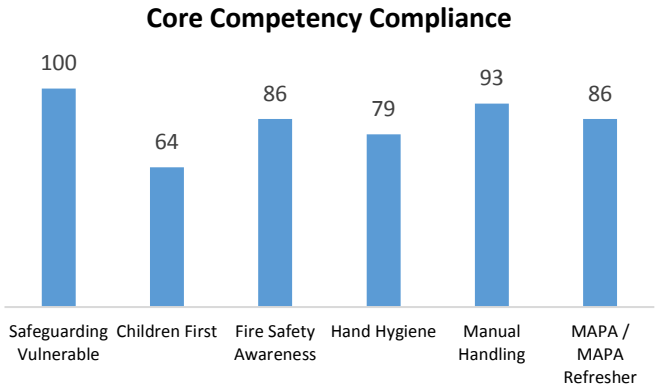
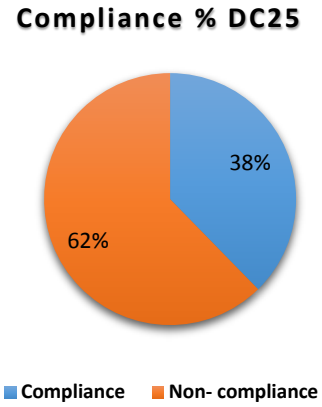
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- Service users would like a more varied diet- CPU send over same type of food for people with dietary requirements.
- Don't enjoy the food sent from CPU.
- Majority of service users commented that they would like more space to keep personal belongings,
- Two service users would like more opportunities to have sensory based activities.
- More one to one activities.
- Would like to go home to my family more often.
- Would like a patio at the front door
- Love sitting in garden during the summer months.
- Home is very comfortable.
- Like having space and time to myself.
- Love my bedroom that was done up.
- Happy with choices and support given in Woodlands 20.
- Enjoy taking part in a wide variety of social activities.
- Enjoy having meals around the dining room table with my friends.
- Staff are very helpful and supportive.

Friends and Family Survey Feedback 2018

- Very happy with the services you provide.
- The staff is first class and my sister loves them.
- Loves the bungalow she lives in, I know she feels safe there.
- I love the way staff take (service user) out for the day she loves it

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is currently no vacancies in this designated centre.	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	This home has a good skill mix in place to ensure the needs of residents are met on a daily basis. Staff include a S/N, HCA, Household staff, Day Service	

	Staff and this home is a practice placement for Student Intellectual Disability Nurses.	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Staff Fire Safety training is out of date, ensure same is completed. Staff need to complete on site fire drill training. Ensure all staff complete, children's first training, hand hygiene, manual handling and MAPA training.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.

Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly throughout 2018.	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	PIC confirmed that any incidents that required a HIQA notification were completed within the correct timeframes.	
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	

Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	Yes all residents had an OK Health Check completed in 2018 by a nurse.	
Ensure each resident has had an Annual Medical Review completed by a GP.	All residents received an AMR by a GP in 2018	

Ensure there is care plans in place for each identified need.		There was poor linkage across OK Health Check, initial indicators and care plans. For one resident there were three care plans developed with no connection to the OK health check or initial indicators. PIC needs to ensure that this information is fed back to staff completing OK Health Check and reviewing red initial indicators to ensure they are completed as per the agreed pathway.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	4 residents have PBSP. All staff are aware of the contents of the PBSPs and the recommended controls to put in place when necessary.	1 service users PBSP has past the review date of Sept 2018- the CNS in behaviour is currently reviewing this. Not all staff in this area have received training on MAPA (refresher) and positive behaviour support training.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	1 identified restrictive practices in place in this designated centre. Gaitor Splints This is the least restrictive and there is a protocols in place.	Continue to trial removing restrictions in 2019.
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	

All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is up to date safeguarding plans in this home.	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	All residents have had monthly keyworker meetings. Weekly service user meetings are held on a Friday and plans are put in place for the following week.	
All residents have access to advocacy services and information about their rights?	All service users have up to date initial indicators regarding advocacy and the information that is available to them.	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outlined in their plan.	Each service user has a communications section in their personal support plan that is updated annually.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	There is a sunroom, sitting room and relaxation/multi-sensory room available to all service users where they can meet their families if they wish. All families are welcome to visit Woodlands 20 whenever they like.	

Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have access to their own possessions and clothes are kept in their own wardrobe sin their room. All linens are laundered regularly and returned to service users.	
Each resident is supported to manage their own financial affairs.	All residents are supported by staff to manage their finances	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Staff are encouraged to provide individual attention to each resident and to speak respectably to all service users.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	Day activation staff take the residents out during the week for social and recreational activities. The PIC has arranged for a bus to be available every weekend for social outings	Ensure a review of PATH is completed to ensure all activities are in line with service users' needs and wishes.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	The house is very homely, all resident's bedrooms are very well decorated to suit their individual taste and likes. Multi-sensory room is very well equipped, relaxing and welcoming. All communal areas bright, airy and tastefully decorated. The bathroom has been suitably decorated and adds to the homely atmosphere of the house. The staff have made a great effort in the house to ensure the environment meets the ladies personal	Assess the home with a view to providing more storage for service users who have requested this.

Environmental Audit **Actions from environmental audits are completed in an effective manner.**	All actions are followed up the PIC each month	
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Residents have expressed their dislikes for the meals that arrive from the CPU, especially for those who have dietary requirements. Where possible service users go to the shop to pick out foods.	Work on cooking in the home to improve the meals provided to service users.
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**

Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff. All risk assessments have been updated to the new format.	Ensure the ICC model is followed to ensure clear identification of risk and clarity on cause and context on all risk assessments. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	An IPC audit was completed at the start of 2018	Ensure all IPC actions identified in the audit are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.**	Daily fire checks completed All PEEPs are fully completed up to date and tested.	A number of staff require fire safety training and on site fire drill training

Staff are trained in fire drills and staff training in evacuation procedures.		
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker	Each resident has had a self-administration of medication assessment completed in the past 12 months.	
There is up to date PRN protocols in place.	All PRNs are up to date and available in the kardex folder in the home	
SAMs trained staff have in date SAMs training,	SAMs trained staff have in date SAMs training	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff complete fire safety training
5	Ensure staff complete on site fire drills.
6	Ensure staff complete Children's First Training
7	Ensure staff complete hand hygiene training

8	Ensure staff complete manual handling training
9	Ensure staff complete MAPA training
10	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
11	Each service users SURA documents should be reviewed annually (or sooner if required)
12	Ensure there is a schedule of meetings for 2019 to ensure staff meetings take place monthly.
13	PIC needs to use the organisational template to ensure key issues are discussed each month.
14	Ensure the OK Health Checks, red initial indicators and care plans are completed as per the agreed pathway.
15	Ensure there is linkage between OK Health Checks, red initial indicators and care plans
16	Ensure 1 service users PBSP is reviewed as it is past the review date.
17	Continue to trial removing restrictions in 2019.
18	Ensure all safeguarding plans are reviewed within the correct timeframes.
19	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
20	Ensure a review of PATH is completed to ensure all activities are in line with service users' needs and wishes.
21	Work on cooking in the home to improve the meals provided to service users.
22	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
23	Ensure a Critical Incident Review is completed after every unplanned hospital admissions.
24	Ensure the ICC model is followed to ensure clear identification of risk and clarity on cause and context on all risk assessments
25	Assess the home with a view to providing more storage for service users who have requested this.
26	Ensure all IPC actions identified in the audit are followed up.
27	A number of staff require fire safety training and on site fire drill training
28	Ensure all issues identified by service users in the service users survey are addressed

Designated Centre 26

Location:	Suncroft, Beech Park, The Paddocks, Balgaddy House
PIC:	Maria Mulvey
Date of Publication:	April 2019

Service User Suggestions for Improvement – (Survey Results / Service User feedback)

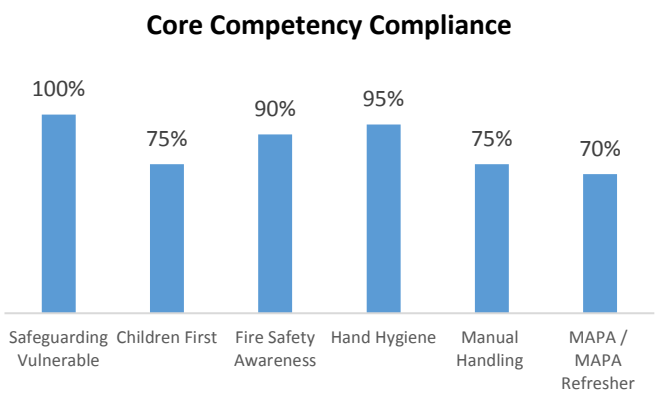
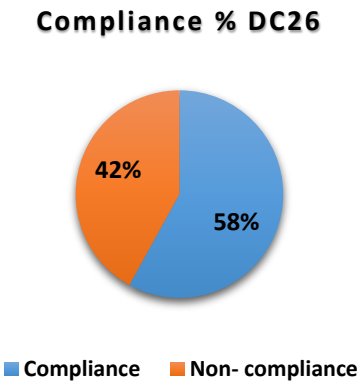
- Unhappy with the lack of transport even though my family were told I would be getting one before I moved in in January 2018.
- House is too hot during the day time and too cold at night
- Don't like agency staff being used Houses is very far away takes me two hours to travel to Lucan Service user is happy and loves her home
- Enjoyed decorating her own room
- With meal choices available
- Would like back garden to be made more user friendly and adapted to my needs

Friends and Family Survey Feedback 2018

Surveys were sent to family and friends in January 2019 unfortunately none were returned for this Designated Centre

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house staff have not signed to say they have read each one in all homes.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced. Ensure staff sign to say they have read all policies
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre.	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is no vacancies in this designated centre.	

Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	This designated centre has a good skill mix in place to ensure the needs of residents are met on a daily basis. **<u>Balgaddy</u>** **Proposed staffing allocation per shift based on 2019 DNA**; 1 R/N Mon-Fri 9-5, 1 HCA 5-9 Mon-Fri, 1 HCA 9-9 Sat, Sun 1 R/N sleepover, 1 HCA waking night, **<u>Beechpark</u>** **Proposed staffing allocation per shift based on 2019 DNA**; 1 HCA 8am-8pm each day, 1 HCA 8-8 waking night, 8am-4pm HCA mon-fri, 3pm-11pm HCA mon-fri, 8am-8pm HCA Sat Sun. **<u>The Paddocks</u>** **Proposed staffing allocation per shift based on 2019 DNA**; 1 sleepover staff 1 staff during the day mon-Friday from 9.30-4.00 (32.5 hours per week) **<u>Suncroft</u>** **Proposed staffing allocation per shift based on 2019 DNA**; 1 waking HCA each night 1 HCA 8.00 am to 8 pm; 1 HCA each day from 5 pm to 11 pm	

The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Staff Fire Safety training is out of date, ensure same is completed. Staff need to complete on site fire drill training. Ensure all staff complete, children's first training, hand hygiene, manual handling and MAPA training.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do.	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in

Personal supports plans is in place and up to date		order to ensure information is correct and relevant.
Regulation 23: Governance and Management	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings are taking place monthly however the agreed organisational template is not being used and minutes are not typed.	Ensure all staff meetings are typed up on the agreed organisational template.
Regulation 30 Volunteers/Students	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 Notification of Incidents	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that required a HIQA notification were completed within the correct timeframes in 2018.	Ensure all incidents that require a HIQA notification are completed within the correct timeframes in 2019.
Regulation 32/33 Absence of the Person in Charge	**Findings**	**Comments and suggestions for improvement**
Person in Charge Knowing who to contact for support/decisions if the PIC is absent.	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 Complaints Procedure	**Findings**	**Comments and suggestions for improvement**
Complaints and concerns are listened to and acted upon in a timely and supportive manner	There is a complaints log in place and all complaints are processed in line with the policy.	

Easy to read guidance and forms available to all Service Users **All complaints recorded on complaints log**		

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service users had an OK Health check in 2018	Ensure all OK Health Checks are reviewed by a nurse.
Ensure each resident has had an Annual Medical Review completed by a GP.	There is no evidence of 5 service users in this DC receiving an AMR in the past twelve months.	
Ensure there is care plans in place for each identified need.	Ensure only relevant information is on red initial indicators as there is currently a lot of red initial indicators. Red initial indicators should signify chronic conditions and acute conditions that may present.	Ensure OK Health Check, red initial indicators and care plans link as per the agreed organisational pathway.

Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	2 service users had PBSP reviewed in 2018 by Psychology 2 service users were referred to Psychology in 2018 1 service user PBSP is due for review by the CNS in Behaviour. All staff were aware of the controls recommended in PBSP.	Follow up on referrals for PBSP.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	Locked front door is in place in Balgaddy House due to risk of service users running out onto main road	Ensure no restrictions are put in place without being put to the restrictive practice committee. Continue to trial removing restrictions in 2019.
Regulation 8 **Protection**	**We did this well:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is safeguarding plans in this designated centre, however some are due for review.	Ensure all safeguarding plans are reviewed within the correct timeframes and if no longer relevant closed off.
All staff must receive safeguarding and Children's First Training		Staff members require Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**

Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	All residents have had monthly keyworker meetings. Weekly service user meetings are taking place in most homes in this designated centre weekly.	Ensure weekly service user meetings take place in all homes.
All residents have access to advocacy services and information about their rights?	There is outside advocacy agencies working with service users in this designated centre. All service users have up to date initial indicators regarding advocacy and the information that is available to them.	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	Each service user has a communications section in their personal support plan that is updated annually.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome to all homes in the designated centre. Staff will support service users to meet families in privacy if they wish.	
Regulation 12 **Personal Possessions**	**We did this well:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have access to their own possessions and clothes are kept in their own wardrobe sin their room. All linens are laundered regularly and returned to service users.	

Each resident is supported to manage their own financial affairs.	All residents are supported by staff to manage their finances	
Regulation 13 **General Welfare & Development**	**We did this well:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	All residents are treated with dignity and respect.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	4 service users attend day service from this designated centre. The rest are activated by staff in the house.	Ensure a review of PATH and goals are completed to ensure all activities are in line with service users' needs and wishes.
Regulation 17 **Premises**	**We did this well:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	**Beechpark** Back garden is very untidy and not fit for service user use at present, House needs to be cleaned and bedroom doors painted. **Suncroft** Clean home in good structural repair, nicely decorated. **The Paddocks** A very messy sitting room but otherwise apartment was nicely decorated. **Balgaddy House** Carpet on hall stairs and landing is very dirty. Query storage of oxygen in another service user's bedroom.	

Environmental Audit **Actions from environmental audits are completed in an effective manner.**	Environmental audits were not taking place monthly in all homes. Where they were taking place all actions were being followed up and completed by the PIC	Ensure environmental audit takes place monthly in each home.
Regulation 18 **Food and Nutrition**	**We did this well:**	**Comments and suggestions for improvement**
Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	All meals are cooked in the home by staff. Service users take part in the planning, preparing and cooking stages where possible.	
Regulation 20 **Information for Individuals**	**We did this well:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**We did this well:**	**Comments and suggestions for improvement**

Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**We did this well:**	**Comments and suggestions for improvement**
Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff. Risk assessments have been updated to the new format.	Ensure the ICC model is followed to ensure clear identification of risk and clarity on cause and context on all risk assessments. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**We did this well:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audits happened in this designated centre at the start of 2018.	PIC to ensure all actions from IPC audits are followed up.
Regulation 28 **Fire Precautions**	**We did this well:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.**	Not all PEEPs are completed correctly.	All PEEPs to be reviewed to ensure they provide all relevant information including latest fire drills. Staff require fire safety awareness training and on site fire drill training.

Staff are trained in fire drills and staff training in evacuation procedures.		
Regulation 29 **Medicines and Pharmaceutical Services**	**We did this well:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker	Self-administration assessments could not be found for all service users.	Ensure all service users have a self-administration of medication assessment completed within the last 12 months.
There is up to date PRN protocols in place.	There was out of date and missing protocols for PRNs in this designated centre.	Ensure all PRNs have up to date protocols available for all service users who require them.
SAMs trained staff have in date SAMs training,	All SAMs trained staff have in date training.	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure staff sign to say they have read all policies
4	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
5	Staff Fire Safety training is out of date, ensure same is completed.
6	Staff need to complete on site fire drill training across the designated centre
7	Ensure all staff complete, children's first training, hand hygiene, manual handling and MAPA training.

8	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
9	Each service users SURA documents should be reviewed annually (or sooner if required).
10	Ensure all staff meetings are typed up on the agreed organisational template.
11	Ensure all incidents that require a HIQA notification are completed within the correct timeframes in 2019.
11	Ensure all OK Health Checks are reviewed by a nurse.
12	Ensure OK Health Check, red initial indicators and care plans link as per the agreed organisational pathway.
13	Follow up on referrals for PBSPs for service users.
14	Ensure no restrictions are put in place without being put to the restrictive practice committee.
15	Continue to trial removing restrictions in 2019.
16	Ensure all safeguarding plans are reviewed within the correct timeframes and if no longer relevant closed off.
17	Ensure weekly service user meetings take place in all homes.
18	Ensure advocacy is spoken about at keyworker meetings so all service users are aware of their rights.
19	Ensure a review of PATH and goals are completed to ensure all activities are in line with service users' needs and wishes.
20	Ensure environmental audit takes place monthly in each home.
21	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
22	A Critical Incident Review will be completed after every unplanned hospital admissions.
23	Ensure all risk assessments follow the ICC model to ensure clear identification of risk and clarity on cause and context on all risk assessments.
24	PIC to ensure all actions to come from IPC audit are followed up.
25	All PEEPs to be reviewed to ensure they provide all relevant information including latest fire drills.
26	Ensure all service users have a self-administration of medication assessment completed within the last 12 months.
27	Ensure all PRNs have up to date protocols available for all service users who require them.
28	Ensure all issues identified from service users survey are addressed.

Designated Centre 27

Location:	Bungalow 11
PIC:	Jocelyn Ferrer
Date of Publication:	April 2019

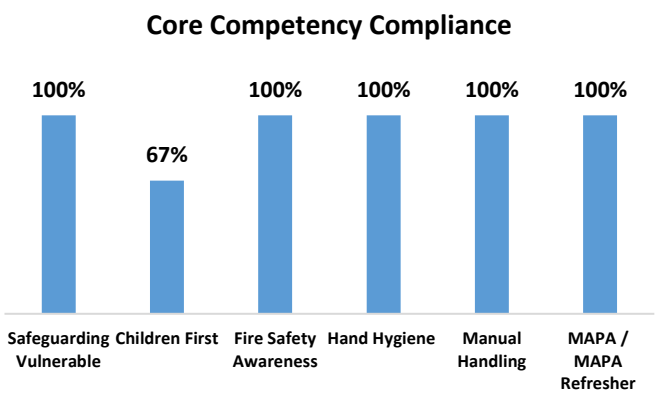
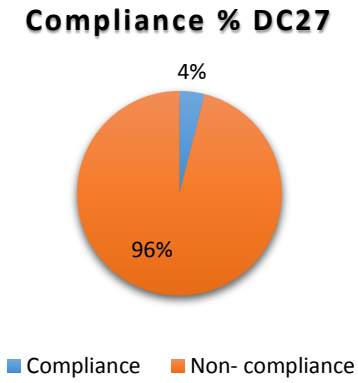
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

No service users surveys were returned from this designated centre although numerous reminders were sent to the PIC.

Friends and Family Survey Feedback 2018

- Important to us to be kept updated with (family member) and any changes in her.
- Want to be involved in reviews and updated on (family members) health and welfare.
- I would like the grounds/ landscape at Stewarts to be better maintained.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is a 1.5 WTE vacancy in this home.	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Agreed staffing allocation per shift as per 2019 DNA**; 2 HCA Night Waking (Night staff provides some support to B.10 as required)	

	1 RN Day 8-8.15pm 4 HCA Day 8-8.15pm 1 Day Service	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure staff complete all core competencies and keep this training up to date as and when required
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive 4 effective supervisions in 2019 as this was not happening in 2018.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**

Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly. PIC was using the agreed organisational template to ensure all key areas are discussed with all staff.	Ensure there is a schedule of staff meetings for 2019 to ensure they place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that occurred in 2018 that were notifiable to HIQA were notified within the correct timeframe.	Ensure all notifiable incidents are reported in the correct timeframe in 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**

Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all residents had an MDT meeting in the past 12 months	
Regulation 6 **Healthcare.**	**Findings**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All service user had an OK Health Check completed in in the past 12 months.	Ensure all service users have an OK Health Check completed in 2019
Ensure each resident has had an Annual Medical Review completed by a GP.	1 service users have no evidence of having had an AMR completed in 2018 by a GP.	Ensure all service users have an AMR completed by a GP in 2019
Ensure there is care plans in place for each identified need.	Not all health issues were identified in brief summary section of OK Health Checks.	PIC to ensure all staff are following the agreed organisational pathway for creating health care plans.

	Red initial indicators should just guide to the correct care plans i.e. chronic and acute conditions the service user has.	
Regulation 7 **Positive Behaviour Support**	**Findings**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	All service users had their PBSP reviewed in July 2018 by the Psychology team.	
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	Locked doors due to a risk of 1 service user absconding. This service user has no road safety awareness and is visually impaired. Locked kitchen due to 1 service user who could present with a serious choking hazard. These restrictions have been reviewed by the restrictive practice committee.	Continue to trial removing restrictions in 2019.
Regulation 8 **Protection**	**Findings:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	Ensure all staff are aware of safeguarding plans.	Ensure all safeguarding plans are reviewed within the correct timeframes.
All staff must receive safeguarding and Children's First Training	Staff members have up to date safeguarding training Staff members have up to date Children's first training	

Regulation 9 **Residents rights**	**Findings**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Not all service users were receiving monthly keyworker meetings in 2018. Service users weekly meetings are taking place but these need to be reviewed as they are generic and the same thing is written every week.	Ensure all service users receive monthly keyworker meetings. Ensure service users meetings are meaningful and provide guidance and direction for the week ahead.
All residents have access to advocacy services and information about their rights?	All service users have initial indicators regarding advocacy these are reviewed annually.	
Regulation 10 **Communication**	**Findings**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users communication initial indicators that detail the level of support needed when communication these are reviewed annually.	
Regulation 11 **Visits**	**Findings**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	Visitors are welcome in this homes at any time.	
Regulation 12 **Personal Possessions**	**Findings:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have control over their own clothes which are kept in their own rooms. All linens are laundered regularly and returned to the resident.	
Each resident is supported to manage their own financial affairs.	Each resident receives staff support for their finances.	

Regulation 13 **General Welfare & Development**	**Findings:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Residents are treated with dignity and respect by all staff.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	Service users in this home take part in a variety of activities	Review PATH and goals to ensure all tasks are meaningful to the service user.
Regulation 17 **Premises**	**Findings:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. **The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.**	There is minor decorative repairs required in this designated centre that the PIC is following up with regularly.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	PIC follows up on all actions identified in environmental audits in an effective manner.	Environmental audit needs to take place monthly.
Regulation 18 **Food and Nutrition**	**Findings:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Begin to cook meals in this designated centre to allow service users to be involved in the planning and cooking of meals.
Regulation 20 **Information for Individuals**	**Findings:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**Findings:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**		A Critical Incident Review will be completed after every unplanned hospital admission. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**Findings:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Ensure all risk assessments have been amended to new format as per risk management policy. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**Findings:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.
Regulation 28 **Fire Precautions**	**Findings:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily checks are completed. PEEPs are fully completed and tested. Ensure all fire drills are recorded on PEEPs	Ensure all fire drills are recorded on PEEPs
Regulation 29 **Medicines and Pharmaceutical Services**	**Findings:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his	Each resident had a self-administration of medication assessment that is reviewed every 12 months.	

or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	All PRN protocols are up to date	
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure current designated centre vacancies are filled to prevent the use of agency staff.
5	Ensure staff complete all core competencies and keep this training up to date as and when required
6	It is important that all staff receive 4 effective supervisions in 2019.
7	Each service users SURA documents should be reviewed annually (or sooner if required).
8	Ensure there is a schedule of staff meetings for 2019 to ensure they place monthly.
9	Ensure all notifiable incidents are reported in the correct timeframe in 2019.
10	Ensure all service users have an OK Health Check completed in 2019
11	Ensure all service users have an AMR completed by a GP in 2019
12	PIC to ensure all staff are following the agreed organisational pathway for creating health care plans.
13	Continue to trial removing restrictions throughout 2019
14	Continue to trial removing restrictions in 2019.
15	Ensure all safeguarding plans are reviewed within the correct timeframes.
16	Ensure all service users receive monthly keyworker meetings.
17	Ensure service users meetings are meaningful and provide guidance and direction for the week ahead.
18	Review PATH and goals to ensure all tasks are meaningful to the service user.
19	Environmental audit needs to take place monthly.

20	Begin to cook meals in this designated centre to allow service users to be involved in the planning and cooking of meals.
21	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
22	A Critical Incident Review will be completed after every unplanned hospital admission.
23	Ensure all risk assessments have been amended to new format as per risk management policy.
24	Ensure all actions identified by the IPC Nurse are followed up with.
25	Ensure all fire drills are recorded on PEEPS
26	Ensure all family issues identified in friends and family survey are addressed.

Designated Centre 28

Location:	House 24
PIC:	Carl Grey
Date of Publication:	April 2019

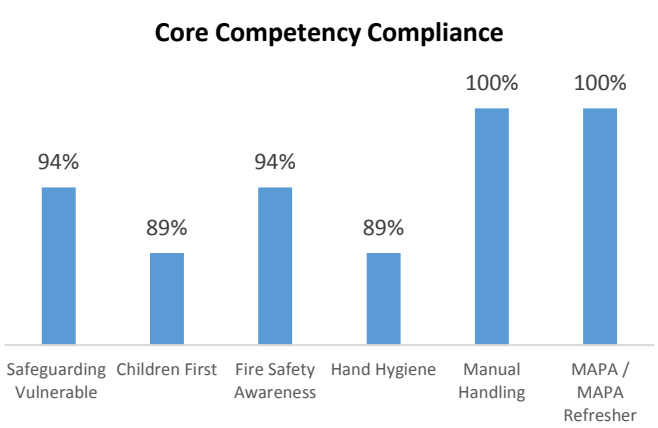
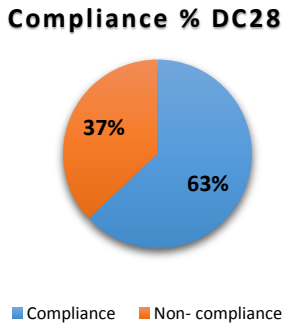
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- Like me bedroom that has been done up.
- Enjoy going out for lunch and bus drives.
- Would like more shows/ plays to be involved in in Stewarts Care.
- Would like people to ring the doorbell before entering.
- Would like more activities, difficult to do activities after 8pm.
- Find s it hard to sleep at night, room reminds service user of the old units.
- Would like to make more of his own dinners, not enough choice.
- Want to move on to the community.
- Would like to have the living area painted.
- Would like to go to Kinvara more often because my family visit when I am there.
- Would like tracking for my room, to make transferring more comfortable for me.

Friends and Family Survey Feedback 2018

Surveys were sent to friends and family members in January 2019. None were returned for Designated Centre 28

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is vacancies in this designated centre.	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	This home has a good skill mix in place to ensure the needs of residents are met on a daily basis. Staff include a S/N, HCA, Household staff, Day Service	

	Staff and this home is a practice placement for Student Intellectual Disability Nurses.	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Staff Fire Safety training is out of date, ensure same is completed. Staff need to complete on site fire drill training. Ensure all staff complete, children's first training, hand hygiene, manual handling and MAPA training.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**

Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were taking place monthly throughout 2018. PIC was using organisational template to ensure all relevant information was discussed.	
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	All incident that were notifiable to HIQA were notified within the correct timeframes.	
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**

Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place and all complaints are processed in line with the policy.	

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	Yes all resident had an MDT meeting in 2018	
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All residents had an OK Health Check in 2018	Ensure all service users receive an OK Health Check in 2019
Ensure each resident has had an Annual Medical Review completed by a GP.	All residents expect one have evidence of having an AMR completed by a GP in 2018	Ensure all residents have an AMR completed by a GP in 2019
Ensure there is care plans in place for each identified need.	Care plans are completed very well in this designated centre and clearly guide practice.	Ensure red initial indicators link to care plans.

Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	All PBSPs have been reviewed by Psychology in the past 12 months. All staff are aware of the PBSPs and the controls recommended in them.	
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A	
Regulation 8 **Protection**	**Findings:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is safeguarding plans in this home.	Ensure all safeguarding plans are reviewed within the correct timeframes a number of safeguarding plans have not been updated in the last six months.
All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**

Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	Service user weekly meetings are taking place.	Ensure all service users are getting monthly keyworker meetings, majority are not receiving meetings monthly. Ensure service user weekly meetings are not generic and are meaningful.
All residents have access to advocacy services and information about their rights?	Advocacy services are active in this house and referrals are made to advocacy services by staff and/ or families when required.	
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication in initial indicators to help guide staff when communicating with each service user. These need to be reviewed annually to ensure they are effective and reflect the service users communication needs.	
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to this designated centre. If requested staff will provide space and privacy to receive guests.	
Regulation 12 **Personal Possessions**	**Findings:**	**Comments and suggestions for improvement**
Each resident has access to and retains control of personal property and possessions.	All residents have access to their possessions at all times. Linen is laundered and returned to service users as soon as possible.	
Each resident is supported to manage their own financial affairs.	All residents receive support from staff with there finances.	

Regulation 13 **General Welfare & Development**	**Findings:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Staff spoke respectably to all residents.	One service user's dignity is currently being compromised as the bathroom is not fit for purpose so they have to use a commode in their bedroom.
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?		A review of resident's goals and PATHs is necessary as meaningful activities were limited during audit.
Regulation 17 **Premises**	**Findings:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. **The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.**	Staff have worked hard to make the house look homely. Curtains around bathroom areas help to uphold resident's dignity.	Service users bedrooms are considerably small.
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	Environmental audits are completed monthly and actions are followed up in an effective manner.	
Regulation 18 **Food and Nutrition**	**Findings:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**		Work on cooking in the home to provide greater choice to service users. This will also allow service user to become part of the planning, preparing and cooking of food
Regulation 20 **Information for Individuals**	**Findings:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**Findings:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is plans to transitions service users from this home.	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**Findings:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Risk assessments need to be updated to the new format in line with the new risk management policy. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**Findings:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit is required in this home.	
Regulation 28 **Fire Precautions**	**Findings:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily fire checks completed	All PEEPs must have Yes or No ticked on them to make the fire evac procedure clear to any staff that come to work in the house. Some staff require fire safety awareness and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**Findings:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and	Each resident has had a self-administration of medication assessment completed in the past 12 months.	

preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	All PRNs are up to date and available in the kardex folder in the home	
SAMs trained staff have in date SAMs training,	N/A	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure staff keep up to date with core competency training including refresher training.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Each service users SURA documents should be reviewed annually (or sooner if required)
7	Ensure all service users receive an OK Health Check in 2019
8	Ensure all residents have an AMR completed by a GP in 2019
9	Ensure red initial indicators link to care plans.
10	Ensure all safeguarding plans are reviewed within the correct timeframes a number of safeguarding plans have not been updated in the last six months.
11	Staff members requires safeguarding training
12	Staff members requires Children's first training
13	Ensure all service users are getting monthly keyworker meetings, majority are not receiving meetings monthly.
14	Ensure service user weekly meetings are not generic and are meaningful.
15	Assess the bathroom for improvements to improve service users dignity.
16	A review of resident's goals and PATHs is necessary as meaningful activities were limited during audit.
17	Service users bedrooms are considerably small.
18	Work on cooking in the home to provide greater choice to service users.

19	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
20	A Critical Incident Review will be completed after every unplanned hospital admissions.
21	Risk assessments need to be updated to the new format in line with the new risk management policy
22	All PEEPs must have Yes or No ticked on them to make the fire evac procedure clear to any staff that come to work in the house.
23	Some staff require fire safety awareness and on site fire drill training
24	Ensure all service users issues identified in the service users surveys are addressed.

Designated Centre 29

Location:	Carraig Apt, 28 The Apt.
PIC:	Chengeto Jeyacheya
Date of Publication:	April 2019

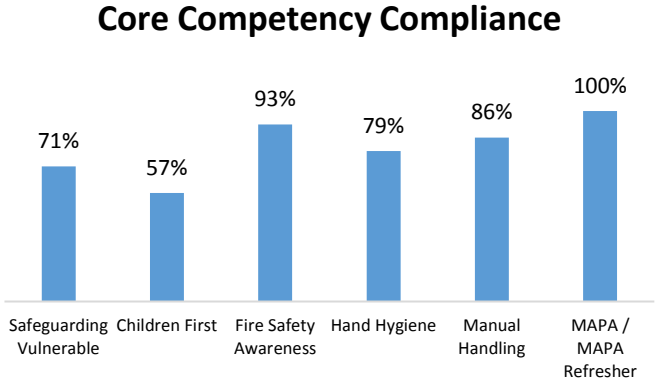
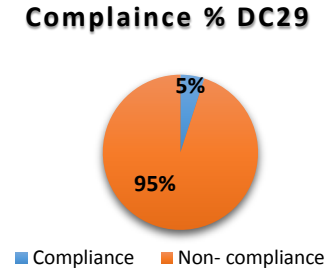
Service User Suggestions for Improvement – (Survey Results / Service User feedback)

- I don't like to take part in activities outside my centre.
- Would like my bedroom to be painted.
- I want to go back to the gym.
- I like having familiar staff that know me.

Friends and Family Survey Feedback 2018

No family and friends surveys were returned for this designated centre.

Capacity and Capability		
Regulation 3: **Statement of Purpose**	**Findings**	**Comments and suggestions for improvement**
Statement of Purpose available to Residents and their Representatives	Statement of purpose is available in folder 1 in the home.	Ensure the person in charge and staff are aware of the contents of the statement of purpose. Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
Regulation 4: **Policies and Procedures**	**Findings**	**Comments and suggestions for improvement**
Knowing where to find policies and understanding what they say (Schedule 5) **All staff have signed Policy Sign off sheets.**	There is a schedule 5 policy folder in the house and staff have signed to say they have read each one.	As policies are continuously being reviewed and ratified, ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
Regulation 14: **Person in Charge**	**Findings**	**Comments and suggestions for improvement**
The registered provider has appointed a person in charge of the designated centre.	There is a Person in Charge in this designated centre	
Regulation 15: **Staffing**	**Findings**	**Comments and suggestions for improvement**
Is the agreed complement of staff in place (numbers and skill mix)?	There is 1.5 WTE vacancies in this designated centre.	
Is the staffing level (and skill set) sufficient to meet the assessed needs of residents?	**Carraig Apt** **Staffing complement as per the 2019 DNA;** 1 HCA Night Waking 1 HCA Day 8-8pm	

	1 HCA 8-12pm, 4-8pm (Mon-Fri) 2 HCA 8-8.15pm Sat + Sun **28 The Apt** **Staffing complement as per the 2019 DNA;** 1 HCA Night Waking 1 HCA Day 8-8.15pm	
The person in charge must ensure there is a planned and actual roster.	A planned and actual roster is available in the home. This is also sent to the Programme Manager for review.	
Regulation 16: **Training & Development**	**Findings**	
Staff have access to appropriate training including refresher training as part of a continuous professional development programme.		Ensure all staff keep up to date with core competency training including any refresher training.
All staff will receive quarterly supervisions from their line manager		It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.

Regulation 21: **Records**	**Findings**	**Comments and suggestions for improvement**
Keeping good records and documentation to evidence the work we do. **Personal supports plans is in place and up to date**	All service users have a personal support plan on SURA and information based on schedule 3 is input here.	Each service users SURA documents should be reviewed annually (or sooner if required) in order to ensure information is correct and relevant.
Regulation 23: **Governance and Management**	**Findings**	**Comments and suggestions for improvement**
Ensuring we follow up on actions from staff meetings, audits etc.	Person in Charge is currently using the compliance plan developed in 2018 to track actions and follow up on all necessary actions.	
Ensuring staff meetings take place monthly	Staff meetings were not taking place monthly throughout 2018.	Ensure there is a schedule of meetings for 2019 to ensure they take place monthly.
Regulation 30 **Volunteers/Students**	**Findings**	**Comments and suggestions for improvement**
Ensuring all Volunteers are supported by staff in their role and responsibilities	N/A No volunteers in this DC at present	
Regulation 31 **Notification of Incidents**	**Findings**	**Comments and suggestions for improvement**
Ensuring we report all HIQA notifiable incidents.	Most incidents that were notifiable to HIQA were notified within the correct timeframes.	Ensure all incidents that are notifiable to HIQA are reported within the appropriate timeframes in 2019.
Regulation 32/33 **Absence of the Person in Charge**	**Findings**	**Comments and suggestions for improvement**
Person in Charge **Knowing who to contact for support/decisions if the PIC is absent.**	N/A at present. All staff are aware of who the Programme Manager is for this Designated Centre. Programme Managers number and on call numbers are available in the Designated Centre so staff are aware of who to contact.	
Regulation 34 **Complaints Procedure**	**Findings**	**Comments and suggestions for improvement**

Complaints and concerns are listened to and acted upon in a timely and supportive manner **Easy to read guidance and forms available to all Service Users** **All complaints recorded on complaints log**	There is a complaints log in place but it needs to be updated to the new format.	Ensure complaints are discussed at service user meetings so all service users are aware of what a complaint is and how to make one.

Quality and Safety		
Regulation 5 **Individual Assessment and Personal Plan**	**Findings:**	**Comments and suggestions for improvement**
Individual Plans **Ensuring people have an up to date plan that tells us about their needs, wishes and goals and the supports they require to maximise their Personal Development and Quality of Life** **Individual Support plans are in an Accessible format**	All residents have an up to date personal support plan that is available to them or their representatives.	
Are all residents MDTs completed for 2018	1 resident did not have an MDT meeting in 2018	Ensure all residents have an MDT meeting in 2019.
Regulation 6 **Healthcare.**	**Findings:**	**Comments and suggestions for improvement**
Ensure there is an OK Health Check completed for each resident	All residents had an OK Health Check in 2018	Ensure all residents have an OK Health check in 2019
Ensure each resident has had an Annual Medical Review completed by a GP.	All residents expect one have evidence of having an AMR completed by a GP in 2018	Ensure all residents have an AMR completed by a GP in 2019.
Ensure there is care plans in place for each identified need.	Care plans are not in line with OK Health Check and AMR. Ensure red initial indicators are reviewed annually.	PIC to ensure that agreed organisational pathway is used for completing OK Health

		Check, red initial indicators (Health) and Care plans.
Regulation 7 **Positive Behaviour Support**	**Findings:**	**Comments and suggestions for improvement**
Where required Positive Behaviour Support Plans are put in place and staff have up to date knowledge and skills to respond to the behaviour that is challenging.	Carraig Apt; Both service users have an in date PBSP reviewed by Psychology 28 The Apt; All PBSPs have been reviewed by CNS Behaviour in the past 12 months. All staff are aware of the PBSPs and the controls recommended in them.	Ensure all staff are aware of service users PBSP.
There are restrictive practice protocols in place for each restrictive practice. Is there evidence that any restrictive practices in use are the least restrictive and that they are being used in line with the persons restrictive practice protocol.	N/A	
Regulation 8 **Protection**	**Findings:**	**Comments and suggestions for improvement**
Making sure we respond to any allegation/concern of abuse and neglect in line with safeguarding policy.	All NIMs forms are fully completed and follow up action forms are completed.	
All safeguarding plans are up to date, effective and staff are aware of safeguarding plans	There is up to date safeguarding plans in this designated centre.	Ensure all safeguarding plans are reviewed within the correct timeframes.

All staff must receive safeguarding and Children's First Training		Staff members requires safeguarding training Staff members requires Children's first training
Regulation 9 **Residents rights**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to have choice and control in their daily lives. This is discussed at monthly keyworker meetings and weekly service user meetings.	In Carraig Apt weekly service user meetings are taking place one to one in place of monthly keyworker meetings. Service users in 28 Apt not receiving monthly keyworker meetings throughout 2018.	Ensure all service users are getting monthly keyworker meetings. Ensure service user weekly meetings are not generic and are meaningful.
All residents have access to advocacy services and information about their rights?	All residents have advocacy initial indicators detailing the level of advocacy support required to that person.	Ensure all advocacy initial indicators are reviewed annually as some have not been updated in a number of years.
Regulation 10 **Communication**	**We did this well**	**Comments and suggestions for improvement**
All staff working with residents are aware of any particular or individual communication supports required and this is outline din their plan.	All service users have up to date communication in initial indicators to help guide staff when communicating with each service user. These need to be reviewed annually to ensure they are effective and reflect the service users communication needs.	Ensure all communication initial indicators are reviewed annually as some have not been updated in a number of years.
Regulation 11 **Visits**	**We did this well**	**Comments and suggestions for improvement**
Individuals are supported to receive visitors without restrictions and are given space and privacy to do so	All visitors are welcome to this designated centre. If requested staff will provide space and privacy to receive guests.	
Regulation 12 **Personal Possessions**	**Findings:**	**Comments and suggestions for improvement**

Each resident has access to and retains control of personal property and possessions.	All residents have access to their own possessions at all times. Linen is laundered and returned to the service users as soon as possible.	
Each resident is supported to manage their own financial affairs.	All service users are supported by staff with their finances.	
Regulation 13 **General Welfare & Development**	**Findings:**	**Comments and suggestions for improvement**
All residents will be treated with dignity and respect. **All practices are person-centred and resident- focussed.**	Staff treat all service users with dignity and respect.	
Do residents have a meaningful day that corresponds with what is recorded in the resident's personal plan/ PATH?	1 service users in this designated centre goes to day services during the week,	A review of resident's goals and PATHs is necessary to ensure all activities are in line with each person's wishes.
Regulation 17 **Premises**	**Findings:**	**Comments and suggestions for improvement**
Making sure the physical environment is clean, comfortable and in good structural and decorative repair. The House is homely and accessible and promote the privacy, dignity and welfare of each person living there.	There is minor maintenance issues being tracked by the PIC of the designated centre.	
Environmental Audit **Actions from environmental audits are completed in an effective manner.**	Environmental audits were not completed monthly in 2018.	Ensure environmental audits are completed monthly throughout 2019 and PIC to follow up on any issues identified.
Regulation 18 **Food and Nutrition**	**Findings:**	**Comments and suggestions for improvement**

Supporting people to have a healthy and nutritious diet – meals are wholesome and nutritious **Support Individuals to buy, prepare and cook their own meals if they so wish** **Individual are involved in meal planning**	Cooking is done in these homes. This allows service user to become part of the planning, preparing and cooking of food.	
Regulation 20 **Information for Individuals**	**Findings:**	**Comments and suggestions for improvement**
A summary of the services and facilities provided; the terms and conditions relating to residency; arrangements for resident involvement in the running of the centre; the procedure respecting complaints;		Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
Regulation 25 **Temporary Absence and Transition**	**Findings:**	**Comments and suggestions for improvement**
Relevant Information about Individuals is passed on to Person/s taking responsibility for their Care Support and Well-being (e.g. Hospital) **Individuals receive the support they need to transition into the service or between Services**	There is planned transitions rom this designated centre.	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
Regulation 26 **Risk Management**	**Findings:**	**Comments and suggestions for improvement**

Managing Risks **There are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies**	Managers and nursing staff have completed the full day risk training programme in line with the new Risk Management Policy. An electronic incident management software solution and online training module on the new incident management software system for all staff.	Risk assessments need to be updated to the new format in line with the new risk management policy. Comprehensive risk audit and incident audit will be completed across designated centres by 30th April 2019.
Regulation 27 **Protection against Infection**	**Findings:**	**Comments and suggestions for improvement**
Infection Control Guidelines are in place **Ensuring good Infection Control procedures are in place.**	IPC audit has taken place in this designated centre.	Ensure all actions identified by the IPC Nurse are followed up with.
Regulation 28 **Fire Precautions**	**Findings:**	**Comments and suggestions for improvement**
Making sure daily checks on equipment and escape routes. **Individual SU evacuation assessment plans and area evacuation procedures are in place and reviewed regularly.** **Staff are trained in fire drills and staff training in evacuation procedures.**	Daily fire checks completed.	Ensure PEEPs state how many staff are required for assisting service users in evacuations. Ensure all fire drills are recorded on PEEPs Some staff require fire safety awareness and on site fire drill training
Regulation 29 **Medicines and Pharmaceutical Services**	**Findings:**	**Comments and suggestions for improvement**
Ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and	Each resident has had a self-administration of medication assessment completed in the past 12 months.	

preferences and in line with his or her age and the nature of his or her disability. To be reviewed annually by the Person in Charge /keyworker		
There is up to date PRN protocols in place.	All PRNs have up to date protocols available in the kardex folder in the home	
SAMs trained staff have in date SAMs training,	Yes	

Recommendations for Team Plan 2019- more detailed plans are available in compliance plan and registered provider visits.

1	Ensure the person in charge and staff are aware of the contents of the statement of purpose.
2	Ensure the statement of person reflects the correct WTE as per the 2019 dependency needs assessment.
3	Ensure when new policies are released that this is communicated to staff, ensure staff read the policy and old policies are replaced.
4	Ensure all staff keep up to date with core competency training including any refresher training.
5	It is important that all staff receive effective supervisions in 2019 as not all staff received 4 last year.
6	Each service users SURA documents should be reviewed annually (or sooner if required)
7	Ensure there is a schedule of meetings for 2019 to ensure they take place monthly.
8	Ensure all incidents that are notifiable to HIQA are reported within the appropriate timeframes in 2019.
9	Ensure complaints are discussed at service user meetings so all service users are aware of what a complaint is and how to make one.
10	Ensure all residents have an MDT meeting in 2019.
11	Ensure all residents have an OK Health check in 2019
12	Ensure all residents have an AMR completed by a GP in 2019.
13	PIC to ensure that agreed organisational pathway is used for completing OK Health Check, red initial indicators (Health) and Care plans.
14	Ensure all staff are aware of service users PBSP.
15	Ensure all safeguarding plans are reviewed within the correct timeframes.
16	Staff members requires safeguarding training
17	Staff members requires Children's first training
18	Ensure all service users are getting monthly keyworker meetings

19	Ensure service user weekly meetings are not generic and are meaningful
20	Ensure all advocacy initial indicators are reviewed annually as some have not been updated in a number of years.
21	Ensure all communication initial indicators are reviewed annually as some have not been updated in a number of years.
22	A review of resident's goals and PATHs is necessary to ensure all activities are in line with each person's wishes.
23	Ensure environmental audits are completed monthly throughout 2019 and PIC to follow up on any issues identified.
24	Summary of services and facilities provided is to be reviewed and amended by the person in charge by the end of July 2019.
25	A Critical Incident Review will be completed after every unplanned hospital admissions. To be completed by the PIC and the Head of Quality and Risk
26	Risk assessments need to be updated to the new format in line with the new risk management policy
27	Ensure all actions identified by the IPC Nurse are followed up with.
28	Ensure PEEPs state how many staff are required for assisting service users in evacuations.
29	Ensure all fire drills are recorded on PEEPs
30	Some staff require fire safety awareness and on site fire drill training