<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Muiriosa Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011849</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Westmeath</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:olivia.mccormack@muiriosa.ie">olivia.mccormack@muiriosa.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Muiriosa Foundation</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Josephine Glackin</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Olivia Gavin</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Jillian Connolly</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Sonia McCague</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>18</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
</tbody>
</table>
About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times
From: 03 April 2014 12:00
To: 03 April 2014 19:30

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 12: Medication Management</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
The purpose of this inspection was to monitor ongoing compliance with Regulations and to follow up on a notification of an allegation or suspicion of abuse which was submitted to the Authority on the 28th January 2014. As a result of this notification the Authority issued a provider led investigation to the designated centre. The provider completed a formal investigation under Trust in Care which was signed off on the 24th March 2014. The allegation was initially being addressed through the complaints policy of the organisation, however on the 16th January 2014 it was decided to initiate a formal internal investigation under the trust in care policy.

On review of the final report, Inspectors were satisfied that the organisation adhered to the organisational policy however identified areas of concern, which were not sufficiently addressed.

This was the first of a two day inspection. Inspectors met with the person in charge at the commencement of the inspection and the provider nominee and the person in charge were present at the conclusion of the inspection. Inspectors also attended three of the community houses out of the four which make up the designated centre. Additional non-compliance was identified in relation to medication management, assessment of risk and supporting individuals who exhibit behaviours that challenge. Inspectors informed the person in charge and the provider nominee that a second day of inspection would be scheduled, however in the interim a report would be issued to assist in initiating actions to rectify the main breaches identified.

Primarily, inspectors formed the judgement that there was a common theme arising throughout all outcomes which pertained to the governance and management of the
designated centre. Inspectors were not satisfied that the systems in place ensured that management were monitoring the practices within the designated centre. Risk was identified in each outcome, and although individually did not present as significant, collectively indicated that an overall risk was present based on the deficits in the governance and management systems.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

| Theme: |
| Effective Services |

| Judgement: |
| Non Compliant - Moderate |

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

| Findings: |
| Inspectors' reviewed a sample of individualised personal plans for residents. Personal plans had a health focus and did not provide adequate information on residents specific social, emotional, participation needs, preferences and preferred routines. Efforts had been made to create person centred plans for residents, however the assessment of the social care needs of residents were not comprehensive. There was evidence of activities that residents attended, however there was an absence of specific and measurable plans to meet the individuals' needs and choices. Inspectors were informed prior to the inspection of the dependency needs of residents. On discussion with the person in charge it became apparent that the needs were based on staff knowledge of residents and no formal assessment tool was utilised. Therefore it could not be ascertained if the needs of residents were being met in the absence of an assessment. As stated in Outcome 17, residents in each community house were supported by one staff with an additional staff available at times throughout the week, to assist with residents attending activities. Inspectors were concerned that the staffing levels had a negative outcome for residents based on the limitations to movement however, as stated previously, in the absence of a formal assessment this was difficult to evaluate. Inspectors were informed by staff that if a resident did not want to attend a given activity, that at times they had to, based on the staffing levels. |
Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

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

Findings:
The designated centre had policies and procedures in place relating to health and safety. However inspectors found them to be generic and not reflective of the actual risk present. There was evidence that a risk was present, particularly in relation to supporting individuals who exhibit behaviours that challenge and the support arrangements in place for both staff and other residents, particularly out of standard office hours as staff worked on their own in the individual community houses. Inspectors were informed of the availability of the person in charge in the event of support being needed, however found evidence that due to the lack of formalised arrangement there were times that physical support may not be available to staff. No assessment of risk had been completed relating to this however the provider nominee informed inspectors that the organisation are currently in the process of reviewing the current informal system. The information available to staff who directly support the residents in relation to health and safety was out of date and not reflective of the information maintained by management.

Inspectors reviewed the maintenance records for the fire equipment and were satisfied that they were serviced at appropriate intervals. There was evidence of good practice in relation to fire drills and that each resident had an individual fire evacuation plan, which accounted for the mobility and cognitive understanding of residents. There was evidence of staff training in relation to fire prevention and management and staff were able to inform inspectors on the actions to be taken in the event of a fire. There was also evidence that residents are familiar with the actions to be taken in the event of a fire.

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services
Judgement:
Non Compliant - Moderate

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

Findings:
As stated previously, the Authority was notified in January 2014 of an allegation or suspicion of abuse to a resident. The designated centre initially implemented to complaints procedure of the organisation as opposed to the policy relating to the safeguarding of residents. Inspectors discussed with the person in charge and the provider nominee that the information which was initially reported to the person in charge did meet the criteria of an allegation of suspicion of abuse, and therefore an unnecessary delay occurred in the initiation of an internal investigation. However once the investigation was initiated, inspectors were satisfied that the organisation followed the appropriate policy and procedures. Despite this, inspectors were still concerned that there were deficits in the information obtained, the evidence of learning from the incident and the positive outcome for the resident. Inspectors were informed that this was still ongoing and are awaiting the information informing the Authority of the outcome.

The organisation has a process in place for supporting individuals who exhibit behaviours that challenge which includes regular reviews of the positive behaviour support plan, completed by the appropriate allied health professional. However despite this system, inspectors were not satisfied that the supports in place were addressing the actual need of the resident as opposed to the day to day manifestation of that need. For example, inspectors were informed that staff were aware of the inappropriate placement of a resident, however this was not documented and there was no evidence that this need was being addressed, despite evidence demonstrating that the individual regularly expresses their dissatisfaction with their residential placement through exhibiting behaviours that challenge.

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.
**Findings:**
The designated centre has an organisation policy in relation to medication management. Inspectors found that although the policy references best practice, it is not reflective of the actual practices within the designated centre. For example, it is not reflective of the arrangements in place regarding the administration of medication if a resident is absent from the designated centre i.e. visiting a family or a friend. Inspectors observed medication being stored in an unlocked cabinet. There was risk identified in the documentation of medication in prescription and administration records. There was evidence of the prescription sheet being altered without the signature of the General Practitioner. There was evidence that medication had not been administered to residents without a clear rationale provided. It was not clear in all instances which medication a resident was receiving as required to assist with alleviating behaviours that challenge. Inspectors informed the person in charge and the provider nominee during the feedback meeting, that there was a risk present with the inconsistencies identified and the information omitted.

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

**Theme:**
Leadership, Governance and Management

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
There is a clear management structure in place with the designated centre. The person in charge is currently absent from the designated centre and the area director is the acting person in charge in their absence. The Authority was not notified of this in the appropriate time frame. Inspectors were not assured at the time of inspection that the management systems were effective resulting in negative outcome for residents. Inspectors identified significant inconsistencies between the organisational policies and procedures and the actual support provided to residents. As stated previously the policies regarding health and safety, risk management and medication management did not reflect the practice observed on inspection. Inconsistencies in documentation and inadequate record keeping provided evidence that the quality of care and the experience of the residents are not being monitored. Inspectors found that assessed needs of residents were not being acted upon for example, identifying inappropriate placement of residents and timely access to G.P services.
### Outcome 17: Workforce

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

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Responsive Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgement:</td>
<td>Non Compliant - Moderate</td>
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</tbody>
</table>

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

**Findings:**
As a result of no formal assessment of the dependency levels and needs of the residents it was difficult for inspectors to assess if the staffing levels were sufficient to meet the needs of the residents. Inspectors found that all staff spoken to were familiar with the residents and had an in depth knowledge. They spoke of the residents in a dignified and respectful manner, and engaged with them in an age appropriate manner. There was inadequate care planning procedures. Residents were being supported based on staff knowledge of them and in the event of a change in staffing or an individual transitioning there was a risk of information not being communicated.

As stated on Outcome 5, there was also a recognition by staff of limitations to individuals based on staff working alone. On the day of inspection, inspectors met with the Human Resource director who informed inspectors of the induction process in place for newly recruited staff. Currently there is no formal appraisal system in place for staff, inspectors were informed that this is in process.
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Jillian Connolly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Outcome 05: Social Care Needs

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

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

Due to the inadequate assessment of need, it cannot be identified if the needs of individuals are being met.

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

Please state the actions you have taken or are planning to take:
Actions Planned:
• We are currently reviewing a range of comprehensive assessment tools with a view to identifying appropriate reference frameworks for staff who will be comprehensively

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
assessing resident’s needs. To be completed by 31st September 2014.
- The resulting assessment and identified support needs will be captured for each individual in the service user’s information system currently under design which will be fully operational by 31st October 2014.
- Once the individual’s assessment of need is in place it will then be updated and reviewed annually and as required by the person in charge.

**Proposed Timescale:** 31/10/2014

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

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk register did not identify all risks associated with the designated centre and therefore did not have appropriate plans in place. For example there was no formal arrangement in place to support staff who were supporting residents in the absence of another staff member.

**Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
Actions Planned:
- A review of the current hazard identification and assessment of risk will be carried out by person in charge. Risk identified will be recorded in risk register and any required control measures will be put in place. A review of same will be added as a standing item on the agenda for all subsequent local team meetings. This will be completed by 30th June 2014.
- Lone working policy and guidelines are currently being drafted. Once finalised staff will be informed of same through local meetings.
- While there are guidelines in place in each location on responding to emergency situations such as staff or residents becoming unwell, or incidents of challenging behaviour, the outcome of the emergency and how it was responded to will also be a standing agenda item for all local meetings to allow for discussion and learning. This will be completed by 30th June 2014.

**Proposed Timescale:** 31/07/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement
in the following respect:
Although staff were able to inform inspectors of the inappropriate placement of a resident which results in behaviours that challenge, there was no evidence of this in the behaviour support plan.

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

Please state the actions you have taken or are planning to take:
Actions taken:
• The Principal Psychologist has committed to spend one day each month conducting a detailed and rigorous review of the behaviour support arrangement with a view to recasting the current behaviour support plan.
• The support needs of the individual in daily activities have been reviewed and support has been directed in terms of the individual’s preferences. Completed by: 17th April 2014
• Revised transport protocols have been implemented with no further incidents reported.
• The family is working very closely with staff team and Psychiatrist in supporting visits home.
• An audit has been undertaken regionally to record and facilitate the monitoring of and where possible eradicate the use of restrictive practices in place. The person in charge and the senior psychologist are responsible for same.
• The monitoring and elimination of restrictive practices is an agenda item for the monthly senior managers meetings.
• Revised guidance on restrictive practices has been completed and training in the application of this guidance will be rolled out. Action to be completed by 31st August 2014.

Action Planned:
• A review of the purpose of the Periodic Service Review in terms of how the individual is supported will take place.
• If additional staff training requirements are identified by the principal psychologist they will be provided.
• Currently an organisational register is being formulated in terms of individuals who present with significant behaviours of concern, which will profile the individual. This register will be completed by 30th September 2014. Enhanced clinical protocols are in the process of being prepared for individuals on this register.

Proposed Timescale: 30/09/2014
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of the actions to be taken as a result of the outcome of the investigation.

**Action Required:**
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

**Actions Planned:**
- The area director and principal psychologist to meet regularly to review the individual’s progress. Proposed Timescale: Immediate.
- Any staff interventions required will be implemented and reviewed between the staff team and the person in charge. Proposed Timescale: Immediate.
- Learning gained from the appropriate interventions is to be incorporated in the individual’s support plans to ensure consistency in team approach.
- The periodic service review meeting will adequately reflect the individual’s progress and or outstanding support needs. Proposed Timescale: Immediate.
- The individuals support needs and progress to be minuted and reviewed at the monthly local team meetings between staff and the person in charge. Proposed Timescale: Immediate.
- Currently an organisational register is being formulated in terms of individuals who present with significant behaviours of concern, which will profile the individual. This register will be completed by 30th September 2014. Enhanced clinical protocols are in the process of being prepared for individuals on this register.

**Proposed Timescale:** 30/09/2014

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**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all medication was stored in a secured cabinet.

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

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

**Actions Taken:**
- The Medication Policy was discussed at all team meetings, the role of staff in adhering to the policy in terms of the proper ordering, receipt, storage and administration of medication was reiterated.
- P.R.N. Protocols were reviewed and staff made aware of actions required in
challenging behaviour incidents.
- The importance of accurate record keeping, regarding the safety of individuals as they transition from day to residential, was emphasised.
- A secure locked medicine cabinet is in place.

Proposed Timescale: All above actions completed by 30th April 2014.

Action Planned.
- The person in charge will conduct a monthly audit in relation to medication management and submit a report on findings and actions required to the regional director. Proposed Timescale: Action to commence and continue from 30th May 2014.
- The findings of the monthly audit will be reported to the staff team. Proposed Timescale: Action to commence and continue from 30th May 2014.
- Individuals who are moving residence and are nominating a General Practitioner in the locality. Proposed Timescale: Action to be completed by 30th September 2014.

Proposed Timescale: To be completed by 30th September 2014

**Proposed Timescale: 30/09/2014**

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The person in charge is currently absent however based on the numerous other roles that the deputy person in charge is responsible for, inspectors found that the systems were not in place to provide for effective outcomes for residents.

**Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
Action Planned:
- The Person in Charge returns from leave on 28th May 2014.
- Recruitment of additional staff who will carry the brief of person in charge within the community houses in the region is currently underway.
- The recruitment process will ensure that the successful candidates meet the requirements of carrying out the role of person in charge.
- The induction that each of the persons in charge will undergo will further equip them to carry out this role.
Proposed Timescale: 31/08/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that effective monitoring occurs of the services provided to residents.

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

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

Actions taken:
• The Person in Charge works a roster which extends outside of nine to five, Monday to Friday hours; this facilitates the monitoring of work practices ensuring positive outcomes for individuals.
• The organisation has a phased formal induction process for all new employees which has expected learning outcomes and timeframes. Additionally the Person in Charge carries out local induction of all new recruits.
• The Person in Charge monitors each house by visiting at least twice weekly. A log book is kept by Person in Charge which is used to record house visits and note outcomes.
• The Person in Charge is present at all scheduled local team meetings and Periodic Service Reviews.

Actions Planned:
• The regional director meets at least monthly with individual area directors to discuss service issues. A tracking system noting issues and associated actions will be put in place.
• The regional director meets at least monthly with the regional management team which comprises of the area directors and the operations manager, to discuss service issues. All meetings are formally minuted.
• The standing items on the regional management team meeting agenda are reviewed frequently to ensure relevance to the region.
• Health and Safety committee meetings take place quarterly. Accidents and Incidents which occurred in the quarter are reviewed in terms of how they occurred and learning is shared.
• Recruitment of additional staff who will carry the brief of person in charge within the community houses in the region is currently underway. Proposed Timeframe 31st August 2014.
• The recruitment process will ensure that the successful candidates meet the regulatory requirements for carrying out the role of person in charge.
• The on call system in relation to all community houses within the region will be fully operational by 31st August 2014.
Proposed Timescale: 31/08/2014

<table>
<thead>
<tr>
<th><strong>Outcome 17: Workforce</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Responsive Workforce</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There is no formal assessment of need in place for residents therefore the appropriate level of staffing cannot be determined.

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

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

**Actions Planned:**
- We are currently reviewing a range of comprehensive assessment tools with a view to identifying appropriate reference frameworks for staff who will be comprehensively assessing resident’s needs. To be completed by 31st September 2014.
- The individual’s assessment of need will be updated and reviewed annually and as required.
- Contact has been made with an appropriate external body to source and identify a validated and transparent methodology for converting information on individual support profile into a reliable estimate of staffing levels throughout the day. Once such a methodology has been identified we will explore how best to implement this methodology within this setting.
- Recruitment of additional staff who will carry the brief of person in charge within the community houses in the region is currently underway. Proposed Timeframe 31st August 2014.
- The recruitment process will ensure that the successful candidates meet the regulatory requirements for carrying out the role of person in charge.

Proposed Timescale: 31/10/2014

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There is no formal appraisal system for staff and/or lone working policy.

**Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

**Action Planned:**
- Lone working Policy and guidelines are currently being drafted and will be in place by
30th June 2014.
- The on call system in relation to all community houses within the region will be fully operational by 31st August 2014.
- Quarterly performance reviews will be introduced from the 1st September 2014. Guidance for line managers on facilitating these reviews is currently being prepared. The performance reviews will be formally documented.

**Proposed Timescale:** 01/09/2014