**Centre name:** A designated centre for people with disabilities operated by Kingsriver Community Holdings Ltd

**Centre ID:** OSV-0002410

**Centre county:** Kilkenny

**Email address:** kingriver@eircom.net

**Type of centre:** Health Act 2004 Section 39 Assistance

**Registered provider:** Kingsriver Community Holdings Ltd

**Provider Nominee:** Pat Phelan

**Lead inspector:** Ide Batan

**Support inspector(s):** Kieran Murphy

**Type of inspection:** Announced

**Number of residents on the date of inspection:** 6

**Number of vacancies on the date of inspection:** 0
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 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 announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 12 March 2014 10:00  
To: 12 March 2014 18:00

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

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**Summary of findings from this inspection**

As part of the inspection inspectors met with residents, the person in charge, the provider, and other staff members. Inspectors observed practices and reviewed documentation.

The community is a shared living community founded in 1986 and provides residential and day care programmes for adults and young people with a variety of special needs on a designated campus in a community setting.

The ethos of the community is that vulnerable people with an intellectual disability live as part of the wider community. This is facilitated by staff, employees (also called volunteers) and their families sharing a home with people with a disability. This inspection primarily focused on governance, staffing, health and safety, premises, risk management and the robustness of clinical supervision systems in place to ensure the quality and safety of care being delivered to residents. Overall, there was an absence of clinical leadership, and a notable lack of an evidence base to care.

There were significant deficits in core areas, fundamental to the quality and safety of care provided to residents such as medication management practices, fire safety, the process of care planning, infection control, health and safety and risk management.
The design and layout of the centre is not suitable for its stated purpose and does not meet residents’ individual and collective needs in a comfortable and homely way.

The person in charge was involved in the day-to-day running of the centre and was found to be accessible to residents and staff. There was evidence that residents were supported to maintain their independence where possible. Inspectors saw that many residents attended various workshops which were on site.

There were activities available internal and external to the centre such as crafts, gardening and woodwork. Residents told inspectors that that they enjoyed going into the local village or to the city.

The findings of the inspection are set out under ten outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The inspectors found that the service was significantly non compliant with the requirements of the Health Act 2007 Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, contraventions included:

- Medication management practices
- health and safety and risk management
- staff training and development
- staff files were not adequate
- resident and family consultation in development of personal plans
- governance of the service
- premises
- statement of purpose.
Outcome 05: Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Findings:
Residents had access to general practitioner (GP) services. Specialist services and allied health care services such as physiotherapy, occupational therapy, speech and language therapy were available through community based referrals. Inspectors saw that there was not timely access to allied services. Therefore residents had to wait long periods of time for appointments which does not maximise opportunities for continuity of treatment or promote best possible health.

Residents’ health and social care needs were assessed using a support intensity scale. Inspectors saw that some residents had multi complex care needs. Care needs were set out in personal care plans, that were revised following review. Inspectors saw that some personal plans were revised on a yearly basis. Inspectors observed that there was no link between the person-centred plan and the actual care being delivered. There was a significant lack of evidence based assessment tools being used for nutrition, skin integrity, behaviours or incontinence care.

The assessments viewed did not contain any multidisciplinary input. Inspectors did not observe that the assessment and planning process used gave direction and coordination to care delivered to residents who had multiple care needs.

In the sample of care plans reviewed there were some inconsistencies in relation to residents’ involvement in the development of their personal plans. It was also unclear if family members were involved in this process.

The person in charge told inspectors that some residents may move into the wider community with adequate supports in place. However, there was no documented evidence that planning to move between services may occur and there was no planned supports aligned with transfers documented.

Some residents did their own laundry and participated in household chores as observed by inspectors. The centre had its own transport. Residents told inspectors that they often went on trips with staff. Some went out to the local pub in the evenings.
Judgment:
Non Compliant - Major

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

Theme:
Effective Services

Findings:
The centre is situated on approximately three acres of land adjacent to a stream and the ruins of a building, over 100 years old, which was in a state of substantial disrepair. The building at one stage was six stories high but now there was no roof and a number of the top stories had crumbled. The service provider outlined that parts of the walls of the building had fallen during recent storms. There was a substantial crack evident on the side of the building adjacent to the main house. Inspectors recommended to the provider that a structural engineer examine the building and provide a report within the next five working days.

It was accessed via a 200 metre entrance driveway leading to a day service workshop. Adjacent to the day service was an open warehouse situated on the bank of the stream. The river was easily accessible throughout the community. There was no fence visible to prevent access to the river and in particular there was no fence adjacent to residential accommodation, the coachouse. Both issues had been outlined in the service’s safety statement. The inspectors did not see any warning signs about the hazard of drowning or accessible life buoys in the event of somebody entering the river.

Further along the river bank a fire assembly point for the residential facilities was located on a pathway adjacent to the residential area. Large trees that had fallen on the pathway and onto a small wall on the river bank during recent storms, were now creating a trip and cut hazard.

The residential facilities were to the rear of the day service and the warehouse. The residential facilities consisted of a main house and a subsidiary building called the coachouse. The main residential house for four residents was about ten meters from the mill. The coachouse, which provided sleeping quarters for two residents, was physically adjoined to the mill via a disused storage area. The south side of the coachouse was built in the stream.

A piece of tile or chimney was noted to have fallen from the roof into the guttering of the main house and was now in danger of falling to the ground. The main house was accessed via a lobby to the side. The lobby contained the washing machine and tumble dryer and the person in charge outlined that the dog slept in this area at night. There
was a bathroom with a toilet and wash-hand basin in the lobby area.

The lobby led to a kitchen/dining area which was bright spacious and clean. A larder storeroom was adjacent to the kitchen and in addition to food storage it contained a medication press for the storage of night medication.

A solid door led from the kitchen to a lounge area with a television and couches. There was remedial fire work visible on the ceiling in the lounge and inspectors noted that some exposed ceiling insulation had plastic bags around it which was an obvious fire hazard. The windows in this lounge area did not close properly and the room was draughty. The central heating in the lounge was supplemented by a portable plug in heater. The provider had outlined that all windows in the house were due for replacement.

A door from the lounge area led to a hallway. There was a bathroom with a toilet, wash-hand basin and shower. The floor of the shower was noted to be visibly unclean and the soap holder on the shower itself was noted to be rusting. The hallway also contained a linen press which had clean towels and sheets that were shared by residents and staff. The hallway contained a main front door.

The hallway led to the main office which had a desk and chair. The wallpaper in the office was noted to be peeling from the walls and not in an adequate state of repair. The office had a fridge freezer with frozen meat and staff food. There was also a large storage freezer which contained bread and vegetables. This freezer was found to be unclean and in need of defrosting.

The office lobby had doorways to four bedrooms. Two bedrooms were used by male residents, the third was used by a staff member and the fourth was used by a family member. The person in charge outlined that she had been advised that this was in contravention of fire regulations and was in the process of decommissioning the office. This will be addressed under Outcome 7. A stairs from the hallway led to the second floor. The railing of the stairs was noted to be unsteady. On the turn of the stairs/landing area, the wooden floor was noted to be in need of repair. This landing area had doors to two staff bedrooms. At the top of the stairs was a bathroom with a toilet, wash-hand basin and a bath with a shower head attached. Two dirty towels were seen on the window ledge outside the bathroom.

Upstairs accommodation consisted of three bedrooms. One was a vacant bedroom which contained a bed and a spare mattress against the wardrobe. This room had glass partition doors leading to a window area. Another volunteer bedroom had access to this shared window area with the spare room. There was a separate entrance to the volunteer's bedroom. There was also a male resident’s bedroom on this floor which had a wash-hand basin.

Next to the resident’s bedroom was a door leading to a corridor. The light in this corridor was noted to be broken. A portable electric heater was behind the door preventing it from opening fully and there was a bookcase on this corridor. Both the heater and the bookcase were noted to be blocking a fire exit.
Further down the corridor there was a doorway which also led into the male resident’s bedroom. The person in charge advised that this doorway was not functioning. The corridor led to two steps down to further accommodation. The second step was noted to be in need of repair. There was a female resident’s bedroom next to the steps. The corridor also had a bedroom for the adult daughter of the provider with access via two doors. There was a bathroom which contained a toilet, wash-hand basin and shower. The laundry basket in this bathroom was noted to be overflowing with clothes in need of laundry. The provider’s bedroom was at the end of this corridor and had a key pad lock on the door. A stairs led into a lobby that contained a medication press for the storage of day time medication. A medication prescribed specifically for one resident was on the top of this medication press.

The coachouse was a building adjacent to the main house and provided two separate bedrooms, each of which was occupied by one male resident. The coachouse was built in the actual stream and was physically connected to the old mill by an unused storage area. Aside from two fire extinguishers there were no fire precautions.

The door to the first bedroom was on the ground floor. This door did not open fully as it was blocked by the door frame. The door also did not close properly and could not guarantee privacy, dignity and security for the resident. There was a large piece of wood on the floor of the threshold which was a trip hazard. In the threshold a large chunk of stone was noticed to be missing from the wall. This ground floor room had approximately 10 bags full of chopped wood.

Due to the location of the coachouse, which had some foundations in the river this ground floor room was dark very damp and cold. There was no insulation or dry lining of the walls visible. There was evidence of recent plumbing works but this had not been plastered over properly leaving large holes next to the pipe work leading directly into this storeroom. There was no evidence of precautions to prevent access by rodents.

A stairs led from this ground floor room to the upstairs accommodation. Lighting was very poor leading from the ground floor up the stairs to the bedrooms. There was a grab rail on one side of the stairs. Access to the bedroom was via a door at the top of the stairs. This door did not close properly. A fire extinguisher was at the top of the stairs. The bedroom contained a bathroom with toilet, wash-hand basin and shower, a resident’s bedroom and a bedroom of a family member of the person in charge which was not in use.

To access the second bedroom in the coachouse inspectors had to leave the first bedroom and walk along the footpath. There was an open drain plainly visible on the footpath which was a significant trip hazard and also with the potential for access by rodents. Access to the second bedroom was via a fire escape type stairs. On entering and exiting this bedroom there was a significant hazard of injury of striking one’s head against the door frame as it was so low. This area contained one male resident’s bedroom, a staff member’s bedroom and a vacant room. There was a bathroom with a toilet, wash-hand basin and a shower on this floor.
Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Findings:
There were no effective fire safety arrangements in place. Inspectors saw a letter from a fire prevention consultancy company dated November 2013 which outlined that a fire alarm system would be installed and commissioned in the residential building by February 2014. This letter also outlined that there would be a new fire detection system in place by March 2014. While inspectors could see that work had commenced on the installation of the fire alarm and fire detection systems these had not been completed either in the main residential building or the coachouse. Inspectors advised the provider to contact the fire officer in the area to ensure compliance with all fire safety regulations.

In addition a number of specific fire hazards were identified by inspectors including:
- exposed ceiling insulation in the lounge room which had plastic bags around it
- four bedrooms on the ground floor of the main building had obstructed escape routes
- the upstairs corridor of the main building had a heater and bookcase blocking escape routes
- there was no evidence of regular fire drills
- staff had not been trained in fire safety and in particular on the use of fire extinguishers.

Fire extinguishers were visible throughout the centre and had all been certified as in good working order in November 2013. There was a fire emergency plan dated 2013. This identified one assembly point. It also outlined arrangements in place to support residents in the event of an evacuation.

There was a risk management policy dated 2014. It did not comply with article 26 (1) as it did not include:
- hazard identification
- measures to control identified risks
- measures to control specified risks including unexpected absence of a resident, accidental injury, aggression and self harm.
- arrangements for incident reporting and learning from incidents
- arrangements to ensure risk control measures are proportional.

There was a centre-specific safety statement. However, this was last reviewed in November 2010 and had last been acknowledged as read by a staff member in November 2011. There were no risk assessments in the safety statement relating to the hazard of the old mill collapsing or a risk assessment relating to the hazard of drowning

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There was an incident reporting system in place but only two incidents had been recorded since July 2011. One of the incidents related to an incident occurring during the absence of the provider and person in charge who were on annual leave.

In relation to infection control inspectors observed the sharing of towels in all bathrooms. There was no disposable hand towels available. This is not in accordance with best practice for the prevention and control of infection. Inspectors also saw that bed linen, face cloths and towels were communally used.

Inspectors saw a laundry basket which was overflowing with dirty clothes in the bathroom and in the corridor of the main building which is not in accordance with best practice for the prevention and control of infection.

During the inspection one resident informed inspectors that he was going to clean the hen house. There was no personal protective equipment such as gloves, overalls or face masks available. This was a hazard to the resident’s health safety and welfare.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Safe Services

**Findings:**
Policies and procedures were in place for the prevention, detection and response to abuse.

Staff with whom inspectors spoke knew the reporting procedure in relation to abuse. However, there were no documented records available that staff were trained in abuse detection and prevention as required by the legislation. The person in charge informed inspectors that she had discussions with staff on abuse. However, no formal accredited training had been provided for any staff member.

During the inspection inspectors observed that all reasonable and proportionate measures were not in place to ensure the protection of a resident. Inspectors found that there was a lack of understanding of the particular vulnerability of people with
disabilities to abuse in particular where concerns had arisen in the past. There were no documented records available to ongoing supports in place for residents who may have experienced abuse in the past. Inspectors had significant concerns in relation to the lack of risk assessments in identified areas of vulnerability where individual safeguards were not in place.

There was no policy on challenging behaviour and inspectors saw that staff had not received training in the management of challenging behaviour. There was no evidence available with regard to risk assessing in line with best practice for any resident that required the use of chemical or physical restraint.

Inspectors saw that residents managed their own monies and had bank accounts. The person in charge said that they did not hold any monies on behalf of residents. There was no policy in place regarding resident’s personal property and possessions.

**Judgment:**
Non Compliant - Major

<table>
<thead>
<tr>
<th>Outcome 11. Healthcare Needs</th>
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<tr>
<td><strong>Residents are supported on an individual basis to achieve and enjoy the best possible health.</strong></td>
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**Theme:**
Health and Development

**Findings:**
The level of support which individual residents required varied as observed by inspectors. There were deficiencies in the management of some aspects of residents’ health care.

As outlined under Outcome 5 there was limited multidisciplinary input for residents. The person in charge said that residents had access to a GP of their choice. However, there were no formal medical records kept on site so inspectors could not see frequency of medical reviews. This lack of systematic management of information causes a potential risk to ensuring residents receive adequate and appropriate care. It can also lead to confusion and potential for error.

There were no appropriate referrals for dietetic reviews. Inspectors saw that one resident required a modified diet. The person in charge informed inspectors that she trained the staff in relation to using modified diets and thickened fluids. There was no evidence that the malnutrition universal screening tool (MUST) which was an established weight monitoring/assessment tool formed part of the resident’s assessment on admission to the centre.

Inspectors saw that only some residents' weight was monitored. However, inspectors could not ascertain if any actions were taken on foot of a resident being overweight or
underweight. There were no menus displayed in the centre which offered choice. On the
day of inspection inspectors observed that all residents received the same meal.

The person in charge told inspectors that if residents would like something different to
eat that they could write it on a post it and it would be facilitated if possible. She
informed inspectors that it would be impossible for one staff member to cook a choice of
meals every day which in total was 13 people between residents and staff. The person
in charge informed inspectors that the food was nutritious as it was home produced. A
staff member informed inspectors that residents could access snacks from the larder
such as cereals or fruit as observed by an inspector.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Health and Development

**Findings:**
Medication administration practices were unsafe. There were no prescription charts to
account for all medicines which would include all medicines received, administered to
residents, given to residents if they went out for a weekend, and any medicines
returned to pharmacy.

Inspectors saw that one month supply of medication was dispensed from the pharmacy
for each resident. As the pharmacy was off site references and resources were not
readily accessible for staff to confirm prescribed medication with identifiable drug
information which should include a physical description of the medication and or colour
photograph of the medication would be essential in the event of the need to withhold a
medication or in the case of a medication being dropped and requiring replacement.

There were two medication cabinets. The keys were kept in pots on top of the cabinets
which anyone could access. One cabinet contained the stock supply and morning
medicines were dispensed from this cabinet which was locked. However, inspectors saw
a medication prescribed for a resident was stored on top of this cabinet which does not
meet any regulatory or professional guidelines. The person in charge put the night
medications in an individual pot for each resident which was placed on a shelf with the
resident’s name and these were stored in the other cabinet.

The person in charge said she was the only person who dealt with the medication
therefore errors did not occur. However, the centre’s medication procedure indicated
that when a resident wants to go to bed they request the medication from the staff
member on duty. There were no risk assessments completed in relation to this system.
of medication management. There were no administration records which would:
• distinguish between routine and once-off medicines
• record any allergies to medicines
• clearly outline the date of medicine initiation and discontinuation
• chart medicines according to their generic name.

Inspectors saw that some medicines were kept in the fridge. These items did not require refrigeration and were stored with food which does not meet best practice in relation to infection control or medication management.

There were no records available in relation to dispensed medications from pharmacy which does not meet best practice in overall medication management. There was no evidence that residents had been afforded the opportunity to consult with a pharmacist.

There was a medication management procedure available however, it required review in order to meet legislative and best practice guidelines. No staff member had completed any medication management training. There was no evidence available that medication management audits were being completed. These practices increase the risk of potential harm to residents and do not meet legislative requirements.

There was no evidence that residents’ medications were monitored and subject to review at regular intervals. There was no evidence that the person in charge or staff promoted the resident’s understanding of his/her health needs relating to medication. Inspectors recommend that regular audit and updated training in medication management would establish review and processes to evaluate the use of medication policies and protocols as part of quality care provision and risk management programmes.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

Findings:
Inspectors were not satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided. For example it stated that three residents were living independently which is inaccurate.

The statement of purpose was kept under review by the provider and had been updated in December 2013. The statement of purpose set out the services and facilities provided.
However, it did not contain all the requirements of Schedule 1 of Regulations. Omissions included:
• any separate facilities for day care
• details of any specific therapeutic techniques used in the centre and arrangements made for their supervision.
• detail the arrangements for residents to access education, training and employment and the arrangements made for residents to attend religious services of their choice.

**Judgment:**
Non Compliant - Moderate

**Outcome 14: Governance and Management**

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

**Theme:**
Leadership, Governance and Management

**Findings:**
Overall, the inspectors found that governance arrangements were inadequate. The centre is a company with charitable status. It is governed by a board of directors who meet on a bimonthly basis. The nominated provider and person in charge live in the residential house with the residents and staff.

The person in charge was actively engaged in the operational management of the house, and based on interactions with the person in charge during the inspection, she did not have an adequate knowledge of 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. There was no evidence that the quality of care and experience of residents was monitored and developed on an ongoing basis. There were not effective management systems in place to support and promote the delivery of safe and quality services as outlined throughout this report.

While the person in charge had over 30 years experience managing the service inspectors formed the judgement that she was not suitably skilled to assume responsibility and accountability for the provision of service. Inspectors formed this judgement through observation, discussion and review of documentation. There was no evidence of continued professional development plans in place. There was no evidence of any tailored training programme to meet assessed needs of residents.
Inspectors saw that an audit by an external company had taken place in 2012. However, there had been little progress made completing the actions identified on this audit.

There was no system in place to effectively manage risk as outlined in detail under Outcome 7. Staff who spoke with the inspectors had not received any formal support or performance management in relation to their performance of their duties or personal development which is a requirement of the Regulations.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Leadership, Governance and Management

**Findings:**
There were no systems in place to support the person in charge in any planned or unplanned absence. The person in charge said that if she is not onsite the provider is on site. However, inspectors saw documentation that an incident occurred during the absence of the provider and person in charge who were on annual leave.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Responsive Workforce

**Findings:**
Inspectors reviewed a sample of staff files and noted that all were not compliant Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
The inspectors were not satisfied that the numbers and skill mix of staff available during the inspection was appropriate to meet residents’ needs. The person in charge was the only staff member with experience in intellectual disability to cater for residents’ needs. The five other staff were sourced through a programme called the European Voluntary Service (EVS). All five staff were unqualified and had very little experience of working with people with disabilities. There was no evidence on any staff file of Garda Síochána vetting.

Five staff had received training on management of actual and potential aggression in 2013. All staff had received anti-bullying training in June 2013. Members of staff had also received training on manual handling, support of people with autism, programme review planning and assessment of needs planning. However, there was not a systematic training programme and no staff member had received fire training.

Inspectors had concerns about the vetting of volunteers. In the minutes of the Board of Directors meeting from 30 July 2013 it was noted that “a staff member's friend had moved in”. The staff member and friend were not fully identified in the minutes of the meeting seen however, the person in charge confirmed there had been no formal vetting of this volunteer to live in the residents’ home.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ide Batan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Kingsriver Community Holdings Ltd</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002410</td>
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<tr>
<td>Date of Inspection:</td>
<td>12 March 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>2 April 2014</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the 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.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors saw that there was not timely and appropriate access to allied services as residents had to wait long periods of time which does not maximise opportunities for continuity of treatment for residents.

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
Medical assessments have been booked with GP for all residents in the next two weeks.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Proposed Timescale: 30/04/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors did not observe that the assessment and planning process used gave direction and coordination to care delivered to residents who had multiple care needs.

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

**Please state the actions you have taken or are planning to take:**
Public health nurse carried out the Waterlow assessment and Barthel test with two residents and assessed needs are already in place. Speech and language therapist has done a swallow assessment and a new swallow care plan is in place, all staff involved were present at the training. Follow-up assessment in one month’s time by speech and language therapy. All residents shall be medically assessed in next two weeks. Referral made to psychiatrist. Referrals made for occupational therapy.

Proposed Timescale: 27/06/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all personal plans were revised on a yearly basis.

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

**Please state the actions you have taken or are planning to take:**
Resident’s personal plans are reviewed yearly since 2007. PCP reviews for residents will start in May. One resident has his plan reviewed every three to four months, this frequency can be increased or decreased depending on behaviour. We will ensure that all evidence of the implementation of actions proposed during plan reviews are documented.

Proposed Timescale: 23/05/2014
<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
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</thead>
<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>There was very limited input from multidisciplinary professionals.</td>
</tr>
</tbody>
</table>

**Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
For future PCP meetings we will invite all relevant professionals while taking into account the residents wishes.

**Proposed Timescale:** 22/05/2014

<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
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</thead>
<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The personal plans did not contain the names of those responsible for pursuing that the outcomes for residents were met.</td>
</tr>
</tbody>
</table>

**Action Required:**
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

**Please state the actions you have taken or are planning to take:**
An action plan will be attached to each plan with the agreed changes and actions to be taken, the reason why, the time it will take and the name of the person responsible for taking the action.

**Proposed Timescale:** 30/05/2014

<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
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</thead>
<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Failing to ensure that residents receive support as they make transitions between services.</td>
</tr>
</tbody>
</table>

**Action Required:**
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.
Please state the actions you have taken or are planning to take:
The community will provide all relevant information to make the transition between services as easy as possible for the resident. We will support the resident, provide training to prepare the resident, accompany him/her on visits to make the transition easy.

Proposed Timescale: 19/12/2014

Outcome 06: Safe and suitable premises
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design and layout of the premises were not fit for its stated purpose. The main house was cold, all windows were due for replacement. The railing of the stairs was noted to be unsteady on the turn of the stairs in the main house the wooden floor was observed to be in need of repair. The light in the upstairs corridor in the main house was broken. Many of the light shades were made of paper which is a fire hazard.

Parts of the wall at the entrance to apartment one of the coachouse were missing. The door to this apartment did not open or close properly and there was a large piece of wood at the entrance which was a trip hazard. Numerous bags of wood were stored inappropriately on the ground floor in apartment one of the coachouse and this ground floor was cold and damp. Poor lighting on the stairs of this apartment was a significant trip hazard. The door of the sleeping quarters did not close properly. On entering and exiting apartment 2 of the coachouse there was a significant risk of injury by striking one's head against the door frame as it was so low.

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

Please state the actions you have taken or are planning to take:
We are looking at quotes from window manufacturers to replace all the single glazed windows with double glazed. We have already booked a local company to install them. Work on the railing of the stairs and loose floor boards will be completed by the 11/04/2014. The light in the upstairs corridor has already been repaired. The Fire Officer informed us that paper light shades were not a fire hazard, however because they are quite old we have decided to replace all with non paper shades.

We have engaged a building contractor to renovate the coachouse. These renovations will include: insulating and plastering all external walls, building a wall by the stairs on the ground floor to completely exclude the remainder of the ground floor. All doors to be replaced and fire doors installed as per agreement with fire officer. All windows will be double glazed, new lighting to be installed and complete electrical installation to be certified. A dormer roof to be installed over entry/exit door on 2nd floor to increase...
ceiling height over this door.

Main house; windows 25/07/2014. All electrical work including emergency lighting 23/05/2014. Fire doors phase two 30/06/2014, phase three 30/03/2015 as agreed with fire officer. Coachouse; renovations completed, including fire detection system, emergency lighting system and all wiring certified 30/06/2014

**Proposed Timescale:** 25/07/2014

**Theme:** Effective Services

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

The premises were not in a good state of repair externally or internally. The provider could not provide documentation that the old building was structurally sound or safe. There was no fencing visible to prevent access to the river. There were no warning signs about the dangers of the river. There were no accessible life buoys in the event of a resident, staff or visitor falling into the river.

Large trees had fallen on the pathway and onto a small wall on the river bank and were now creating risk of potential injury to residents, staff or visitors. A tile had fallen from the roof into the guttering of the main house and it was in danger of falling to the ground.

There was an open drain plainly visible on the footpath outside the coachouse which was a significant risk to residents, staff or visitors.

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

**Please state the actions you have taken or are planning to take:**
A Historic Building and Conservation Engineering company carried out a survey of the old buildings.

We are employing the services of a fencing company to erect 200 metres of post and rail fencing all along the river from the coachouse to the front field. Fencing will be completed by 18/4/14.

The trees felled in the storm are almost removed (will be by 4/4/14) and we will then immediately repair the broken wall.

The tile from the roof has already been removed. The foot path outside the coachouse will be redone and the exposed drain will be covered.

**Proposed Timescale:** 30/06/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises were not clean or suitably decorated. The floor of the shower in the bathroom of the main house was noted to be unclean. The soap holder in the shower area was rusting. The freezer in the main building was unclean and in need of defrosting. The fridge used by staff was observed to be unclean. The wall paper in the office area in the main house was peeling from the walls and was not in an adequate state of repair.

Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
The bathroom in the main house will be completely redone. This will include retiling floor and tiling all four walls to ceiling height. To be completed by 16 May 2014. In agreement with the fire officer the room has had the deep freeze and fridge have been removed as has all the wall shelving. This area has now become a lobby or hall area. The wall with the peeling wallpaper will be taken down and replaced with a new wall approximately one metre away, increasing the bedroom sizes.

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that assistive technology, aids and appliances to support and promote the full capabilities and independence of residents were not available.

Action Required:
Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

Please state the actions you have taken or are planning to take:
Assistive technology is not required or for any of our residents. Three residents have their own laptops, tablets. A PC is available for all residents in the piano area. Broadband is available throughout the main house and coachouse.

Proposed Timescale: 30/04/2014
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure best practice in relation to achieving and promoting accessibility. Inspectors observed many hazards internally and externally as outlined in the main text of this report which impeded accessibility for residents.

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

Please state the actions you have taken or are planning to take:
Currently only two of our residents have slight mobility issues, for example both can climb stairs but feel more secure if they hold someone’s hand. Both have accommodation on the ground floor and also have access to toilets, shower, dining and social rooms also on ground floor. If this were to change we would review same and any adaptations if necessary.

Proposed Timescale: 30/04/2014

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure provision for matters as set out in Schedule 1.

- Adequate space and suitable storage facilities for personal use of residents
- ventilation, heating and lighting suitable for residents in all parts of the designated centre which are used by residents
- a separate kitchen area with suitable and sufficient cooking facilities, kitchen equipment and tableware
- baths, showers and toilets of a sufficient number and standard suitable to meet the needs of residents
- suitable arrangements for the disposal of general and clinical waste when required.

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

Please state the actions you have taken or are planning to take:
All residents have their own rooms which have an adequate supply of storage including wardrobes and chest of drawers. The new windows when fitted will have a security stay which will allow opening of all windows to provide ventilation if required. We have a 200Kw fully automated wood chip boiler which is more than adequate for all our heating needs. Lighting is provided in all areas of main house both internally and
externally. The renovations in the coachouse will provide more than adequate lighting in this area.

We have a separate complete kitchen and dining area in the day service. This area is available to all residents for use to dine separately or learn to cook if they so wish. Supervision would also be available if required. We also have a large recreational area available to all residents with pool tables, table tennis, training bikes, cross trainer, also a large field for hurling and soccer.

We have a contract with a waste and recycling company for two general waste wheelie bins, collected weekly and two recycling wheelie bins, collected fortnightly.

**Proposed Timescale:** 30/06/2014

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**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:**
There was not effective arrangements in place to identify and manage risk.

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

**Please state the actions you have taken or are planning to take:**
A detailed risk management policy will be put in place which will set out clearly how all risks are assessed, managed and monitored across the service. It will include hazard identification throughout the centre. We will do this in conjunction with health and safety and risk management training. Training will be done in April, policy will be developed immediately after this.

**Proposed Timescale:** 27/06/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy did not include arrangements for the identification, recording and investigation of and learning from, serious incidents or adverse events involving residents.
**Action Required:**
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
This will be included in the policy that we will develop. After a serious incident or adverse event we will review as a team the risk management policy and the risk assessment. Incident report form will be filled out and followed up.

**Proposed Timescale:** 27/06/2014
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The current systems in place to manage risk were not effective.

**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:**
We will formally review our policies, practices and systems with regard to risk assessment and management with the support of external specialists and we will make necessary amendments to reflect regulatory and best practice requirement, while taking into account the size of the service and the need for positive risk taking in delivering a person centred service.

An emergency management plan will be developed as part of the health and safety training.

**Proposed Timescale:** 27/06/2014
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy did not meet the requirements of legislation. It did not cover the unexplained absence of a resident.

**Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.
Please state the actions you have taken or are planning to take:
This will be set out in the detailed risk management policy. Staff training will follow up on the procedures.

**Proposed Timescale:** 27/06/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy did not include the measures in place to prevent accidental injury to residents, staff or visitors.

**Action Required:**
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
The risk management policy and health and safety policy will include this. Staff and residents training will follow this up.

**Proposed Timescale:** 27/06/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy did not include measures in place to control violence and aggression.

**Action Required:**
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
This will be included in our risk management policy. Staff has participated in CPI/MAPA training. A policy for behaviour that challenges is in the process of being developed in conjunction with this. Health and safety policy, adult protection policy, and complaints policy are already in place. Training in adult protection, risk management and assessment will be done in April 2014. This training will include the development of a comprehensive risk management policy and a risk register for the service.

**Proposed Timescale:** 27/06/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to cover self-harm.

Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
This will be included in the risk management policy. One of our staff has done self-harm awareness training. We will organise a training for all staff before September 2014. It will become part of our annual training calendar.

Proposed Timescale: 27/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed the sharing of towels in all bathrooms. There was no disposable hand towels available. This is not in accordance with best practice for the prevention and control of infection. Inspectors saw that bed linen, face cloths and towels were communally used. Inspectors saw that one resident was going to clean the hen house and did not use any personal protective equipment. Inspectors saw a laundry basket which was overflowing with dirty clothes in the bathroom.

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

Please state the actions you have taken or are planning to take:
Procedures will be put in place which will follow the advice of health care professionals, the HSE, and the standards for the prevention and control of healthcare associated infections. We will develop an infection control policy which will reflect this. Some measurements have already been put in place: paper hand towels in all common toilets, use of a steam cleaner, individual towels and bed clothes. All walls in downstairs toilet will be completely tiled and renewed.

Proposed Timescale: 27/06/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not effective fire safety management systems in place.

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

Please state the actions you have taken or are planning to take:
With the advice and support of Kilkenny’s Chief Fire Officer we are putting in place a very effective fire safety management plan for Kingsriver. The plan consists of 14 sections contained in a Fire Safety Register designed and created by the Chief Fire Officer himself.
The 14 sections are:


Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not adequate precautions in place against the risk of fire.

Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
We have decided to change the company we employ to supply our fire fighting equipment to another company who will provide a more comprehensive package to include maintenance, periodic testing and training. A contact is in place

Proposed Timescale: 30/05/2014
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were not adequate arrangements in place for maintaining means of escape, building fabric and building services.

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

**Please state the actions you have taken or are planning to take:**
We now have a comprehensive Service and Maintenance package for our Fire Detection and Alarm System and Fire extinguishers and also includes Training. We also have a maintenance contract with a company to maintain the woodchip boiler. All exit doors have been fitted with thumb locks and new windows will be in place end of July. We have agreed a plan of action with the Chief Fire Officer and also have contracted the services of an engineering and fire consultancy firm from Clonmel. The plan is based on a 10 page 96 question checklist also designed by the Chief Fire Officer.

**Proposed Timescale:** 30/07/2014

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**Theme: Effective Services**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that there is adequate means of escape including emergency lighting. Inspectors observed that upstairs in the main building that a heater and book case were blocking escape routes. Four bedrooms on the ground floor of the main building had obstructed escape routes.

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

**Please state the actions you have taken or are planning to take:**
We have 4 exit doors in the main house. The new windows will employ a security stay which can easily be opened to provide means of escape in an emergency. Emergency Lighting and signage will be installed in the main house by end of April. The system as advised by the Chief Officer will also have a central emergency test facility.

**Proposed Timescale:** 30/07/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not adequate systems in place for detecting, containing and extinguishing fires.

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

Please state the actions you have taken or are planning to take:
We have just completed the installation of an L1 (X) detection system and a similar system will be installed in the coachouse by 16/05/14. Both systems will be connected. Our plan of action involves a phased replacement of all doors with certified fire doors. Mattresses will all have to be fire resistant. Fire extinguishers are currently compliant and we have a maintenance contract.

Proposed Timescale: 30/07/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that all staff had received suitable fire training.

Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
We are putting in place a comprehensive plan of emergency procedures. We have given the Chief Fire Officer drawings listing construction details such as stone walls, timber frame areas, an agreed room identification plan also exit doors and windows (including their size and scope) location of fire doors, electrical distribution boards and fire alarm panel. Also a ledger showing fire extinguishers, fire alarm panel, smoke detectors, heat detectors, electrical panels. We have contracted “Guardian Fire” to do Fire Prevention Training for all staff.

Proposed Timescale: 30/05/2014
### Theme: Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that fire drills take place at suitable intervals.

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

**Please state the actions you have taken or are planning to take:**
We are carrying out fire drills with staff and residents. We have developed a Fire Evacuation Plan which has been agreed with the Chief Fire Officer. We also have an individual diagram for every resident and staff showing exit routes to be taken in case of a fire. The fire drills use these routes which are varied depending on location of fire.

**Proposed Timescale:** 30/05/2014

### Theme: Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that the procedure to be followed in the event of a fire was displayed in a prominent position.

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

**Please state the actions you have taken or are planning to take:**
A laminated copy of the fire evacuation plan and a laminated copy of the diagram of the individualised evacuation routes are attached to the back of every bedroom door.

**Proposed Timescale:** 30/04/2014

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

Please state the actions you have taken or are planning to take:
Person in charge has undertaken comprehensive training in clinic supervision and management associated with challenging behaviour; counselling, psychology and therapy; challenging behaviour, positive supports and CPI.

Behavioural support coordinator, is trained in cognitive behavioural skills for practice, multi-element behavioural support competence, self harm awareness, abuse awareness and protection, mental health first aid training, CPI, health and safety and child protection.

Person in charge and behavioural support coordinator provides training to all staff appropriate to their role, this on the ground training and mentoring and that while records have not been maintained traditionally, they will from here on in. Four EVS staff have up to date management of actual and potential aggression training (valid until 2014).

Policy on challenging behaviour is being written and will be completed by 30 May 2014.

Staff training records and staff personnel files will be reformed to make all evidence readily accessible. This will be completed by 30 May 2014.

| Proposed Timescale: | 30/04/2014 |
| Theme: | Safe Services |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in line with national policy and evidence based practice.

Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
Where restrictive physical or environmental procedures need to be undertaken these are done strictly in consultation with relevant HSE Multi-disciplinary professionals and/or with the resident’s medical practitioner.

Chemical restraint is in strict accordance with residents and/or representative’s consent, by their medical professional in accordance with national policy and evidence based...
A policy on restrictive practices will be aligned to our behaviour that challenges policy. All restrictive practices will be written up, and regularly reviewed. Records will demonstrate that they are only used when absolutely necessary, that they will be for the shortest time possible and that less restrictive approaches will always be tried first. Training in Risk Assessment and Management is scheduled to be completed by 30 June 2014.

Updating of risk assessment procedures will be completed by 31 July 2014. All records will be reformed to reflect the evidence and make evidence accessible on completion.

**Proposed Timescale:** 31/07/2014  
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was no evidence to suggest that all residents were protected from abuse.

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

**Please state the actions you have taken or are planning to take:**  
Behavioural support coordinator has abuse awareness and protection training. All EVS staff receives induction training in abuse awareness. All residents have received training in abuse awareness, prevention, detection and response, by an outside agency. For 2014 this will be completed by 31 July 2014.

Evidence in relation to ongoing supports for residents who may have experienced abuse in the past will be recorded. Records will be reformed to reflect this on receipt of evidence from social worker concerned. A separate risk assessment has been undertaken and actions have been put in place to eliminate any risk. All records are being reformed to reflect the evidence and make evidence accessible.

**Proposed Timescale:** 31/07/2014  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
There was no evidence that all staff had received training in the prevention, detection and response to abuse.

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

**Please state the actions you have taken or are planning to take:**
Annual training will be provided to all staff in abuse awareness, prevention, detection and response, by an outside agency. For 2014 this will be completed by 31 July 2014. Records are being reformed to reflect the evidence and make evidence accessible.

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

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that residents have appropriate and timely access to allied health professionals.

**Action Required:**
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

**Please state the actions you have taken or are planning to take:**
All residents are in receipt of medical card and services by allied health professionals. All residents are being assessed by their GP on the 9 April 2014 and this will include an assessment of allied health professional requirements. Where necessary, private access to services are in consultation with the resident and their family/guardian.

**Proposed Timescale:** 09/04/2014

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**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence to suggest that residents were supported to prepare and cook their own meals.

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

**Please state the actions you have taken or are planning to take:**
Separate kitchen facilities, to cater for residents who wish to prepare and cook their own meals, is provided. Where residents choose to do so, support is provided to buy, prepare and cook the meals.
Proposed Timescale: 02/04/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that residents were offered choice at meal times.

Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
Food and nutrition is based on best practice and the principles of the food pyramid. Person in charge is an ex-tutor of cooking in the previously named ANCO Skills Foundation Course. Regulatory guidance for residential services for older people (HIQA) food and nutrition requirements are being followed. MUST Screening Tool is being implemented.

The HSE community dietician is providing support, guidance and training. Residents are the decision makers in menu planning. Residents receive training in healthy and balanced menu planning and preferences. Photo/text format is used to ensure all residents are enabled to actively participate. Records will demonstrate this in the future.

Proposed Timescale: 30/05/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence to suggest that meals were consistent with each resident’s individual dietary needs and preferences.

Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident’s individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
MUST Screening Tool is being implemented. One resident was assessed by the speech and language therapist on Thursday 27 March 2014 and a swallow care plan was put in place. The plan will be regularly assessed and will be reviewed in three months time or earlier if deemed necessary required actions are implemented. All staff involved in preparing his meals have been trained in correct consistency of food, liquids and mouth hygiene by the speech and language therapist.
Each resident has an annual health screening by his or her GP. Annual health checks are next scheduled for all residents on 9 April 2014. Where assessment shows that a resident has special dietary needs, this is implemented according to the plan provided by the medical practitioner. Advice where necessary is obtained from the HSE community dietician.

**Proposed Timescale:** 09/04/2014

### Outcome 12. Medication Management

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence to suggest that a pharmacist was readily available to residents.

**Action Required:**
Under Regulation 29 (1) you are required to: Ensure that a pharmacist of the resident's choice or a pharmacist acceptable to the resident, is as far as is practicable, made available to each resident.

**Please state the actions you have taken or are planning to take:**
Acceptable pharmacist will be available to meet residents at the centre on a regular basis as far as is practicable on an as needs basis. Pharmacist has confirmed this in writing.

**Proposed Timescale:** 30/04/2014

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to provide appropriate support to residents in his/her dealings with the pharmacist.

**Action Required:**
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

**Please state the actions you have taken or are planning to take:**
Acceptable pharmacist will be available to meet residents at the centre on a regular basis as far as is practicable on an as needs basis. Pharmacist has confirmed this in writing. Most recent meeting will be effected by 30 April 2014. Records will be maintained.
**Proposed Timescale:** 30/04/2014  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Failing to ensure that appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines were in accordance with best practice and regulatory requirements.

**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:**  
Medication management training is scheduled for completion by 30 June 2014. Medication policy and procedures will be amended to reflect training and best practice in ordering, receipt, prescribing, storing, disposal and administration of medicines, by

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**Proposed Timescale:** 30/06/2014  
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
There were no medication administration records.

**Action Required:**  
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**  
There are medication administration records available. These are maintained in a separate medication file. Records are being reformed to reflect the evidence and make evidence accessible in resident’s care plan file.

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**Proposed Timescale:** 30/04/2014
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no risk assessments to suggest that residents were encouraged to take responsibility for his or her own medications.

**Action Required:**
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

**Please state the actions you have taken or are planning to take:**
Following medication management training and risk assessment training, a risk assessment will be made of those residents taking medication. This risk assessment will include taking responsibility for his or her own medications.
This will be done by 30 July 2014.
Interim measures will include administration of medication using blister packs, from the month of April, 2014.
Records will be reformed to reflect evidence.

**Proposed Timescale:** 30/07/2014

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**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that the statement of purpose contained all the matters as set out in Schedule 1 of the Regulations.

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

**Please state the actions you have taken or are planning to take:**
The Statement of Purpose will be reviewed and updated to more accurately reflect the services provided at the centre by 30 April 2014.

**Proposed Timescale:** 30/04/2014
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that the statement of purpose was made available to residents or their representatives.

**Action Required:**
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

**Please state the actions you have taken or are planning to take:**
On completion of the revised and updated Statement of Purpose a copy will be made available to each resident or their representatives. To be completed by 30 May 2014.

**Proposed Timescale:** 30/04/2014

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**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
It was not evident to inspectors that the person in charge had the required skills to manage the service having regard to the statement of purpose and needs of residents.

**Action Required:**
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

**Please state the actions you have taken or are planning to take:**
The Person in Charge is a full time position. The Person in Charge has the necessary qualifications skills and experience to manage the designated centre. Person in charge is also trained in personal care for people with physical disabilities at the Centre for Independent Living at Berkeley California and Camphill Communities of Ireland. Person in charge has continuous professional development in all areas relevant to the care and development of people in her care. Additional nursing care is in strict consultation with community services multi-disciplinary professionals and/or medical professionals. Personnel file contains a complete CV and is being reformed to reflect the evidence and make evidence more accessible.

**Proposed Timescale:** 02/04/2014
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that all of the documents specified in Schedule 2 were available for the person in charge.

Action Required:
Under Regulation 14 (5) you are required to: Obtain the information and documents specified in Schedule 2 in respect of the person in charge.

Please state the actions you have taken or are planning to take:
Personnel files will be reformed to make all evidence readily accessible. This will be completed by 30 April 2014. Garda Vetting is in application.

Proposed Timescale: 30/04/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that the service provided to residents was safe, consistent and effectively monitored. There was a significant lack of risk assessments and awareness in relation to fire safety, medication management, vulnerable adults, clinical risk management and vetting of staff and volunteers. There was no consistent review of quality and safety of care which monitor effectiveness of 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:
A very detailed risk management policy which sets out how risks are assessed and how they are managed and monitored across the Community is being developed. This policy will include the overall process for managing risks, including health and safety risks and risks to residents. The implementation of this overall policy would identify and address risks and most importantly would avoid them. We will formally review our policies, practices and systems with regard to assessment and risk management with the support of external specialists and we will make the necessary amendments to reflect regulatory and best practice requirements, while taking cognisance of the size of the service and the need for positive risk taking in delivering a person centred service. We will receive centre specific focussed training to address fire safety, environmental risks, infection control risks, and ultimately management systems which will ensure quality and safety of care and which the Community will review and monitor on a regular basis. Health & Safety Audit contract in place (6 monthly intervals). Clinical Risk Management Training is scheduled for May 2014.
Medication Management is currently under review to include medication management training. Consultation with pharmacist has taken place and recommendations including use of blister packs, are being implemented throughout the month of April. Care plans and person centred plans are completed for all residents annually or more frequently as deemed necessary. Behavioural support plans are reviewed on a needs basis and at least 6-monthly intervals.

Systematic Intensity Scale is completed for all residents and feeds into the care plan and person centred plans.

Country of Origin EU Accredited sending organisations and/or Police Vetting is in place for all European Voluntary Service staff.

Garda Vetting of all staff is in process.

All records are being reformed to reflect the evidence and make evidence accessible.

**Proposed Timescale:** 27/06/2014

**Theme:** Leadership, Governance and Management

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

There were no unannounced visits carried out by a person nominated by the registered provider as there were no reports available.

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

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

Fire safety prevention equipment maintenance and testing contract in place (quarterly intervals). Fire safety equipment contract in place (annually). Health & safety audit contract in place (6 monthly intervals).

Unannounced 6-monthly visits will commence June 27 2014 in compliance with regulation 23(2) with a written report.

Records are being reformed to reflect the evidence and make evidence accessible.

**Proposed Timescale:** 27/06/2014
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no arrangements in place to support, develop and performance manage all staff.

**Action Required:**
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

**Please state the actions you have taken or are planning to take:**
Staff Appraisals for all EVS staff are conducted quarterly. Confidential personal mentoring (supervision), independent of the centre is in place for all EVS staff. Staff appraisals for all other staff are in progress and scheduled for completion by December 2014 and annually thereafter.
Internal supervision of staff by person in charge happens at regular staff meetings and are recorded. Supervision takes place also during work time as person in charge is present full time.

Supervision for direct care staff is being sourced. Staff training needs identification are ongoing and reviewed at the beginning of each calendar year and on as needs basis. An annual training plan is being developed.
Records are being reformed to reflect the evidence and make evidence accessible.

**Proposed Timescale:** 12/12/2014

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**Outcome 15: Absence of the person in charge**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no deputy person in charge to assume responsibility and accountability for the provision of service in the absence of the person in charge.

**Action Required:**
Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.

**Please state the actions you have taken or are planning to take:**
We have a panel of two trained staff available to take responsibility in the absence of the person in charge. We are developing a policy document which specifies our governance arrangements and this will include cover for absence. Personnel files will be reformed to make all qualification evidence readily accessible. This will be completed by
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no deputy nominated on behalf of the person in charge in her absence.

**Action Required:**
Under Regulation 33 (2) (c) you are required to: Give notice in writing to the Chief Inspector of the name, address and qualifications of the person who will be or was responsible for the designated centre during the absence of the person in charge.

**Please state the actions you have taken or are planning to take:**
Notice will be given in writing with the required details of the panel member who will/is responsible for the management of the centre in the absence of the person in charge.

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failing to ensure that the qualifications and skill mix of staff was appropriate to the assessed needs of residents.

**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:**
All Senior Staff have qualifications, skills and experience to support an appropriate mix necessary for the assessed needs and number of residents. General Care support staff (EVS staff) social care related backgrounds and previous experience working with people with a disability. Skills such as linguistics/communications, Assistive Technology expertise, cookery, gardening, crafts to contribute to the staff skills mix. All records are being reformed to reflect the evidence and make evidence accessible.

| Proposed Timescale: 02/05/2014 |
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of any nursing care input for residents. Inspectors observed that there was a lack of evidence based care provided to residents such as skin integrity, nutrition continence and mobility to meet the assessed needs of the resident population. There was a significant deficit in care practices. Inspectors observed such practices were not in line with national policy and best practice in relation to consent, restraint, medication management and infection control.

Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
Where the assessed needs of the resident requires nursing care this is provided by the public health nurse (PHN). Advice and training where required, is also provided by the PHN. Assessments for skin integrity and mobility have been carried out recently. One resident has been assessed as requiring therapeutic overlay mattress and seat cushion. This has been provided.

Current incontinence of this resident is being monitored by the PHN and staff and will be assessed by medical practitioner on 2 April 2014. PHN considers current staff practice is appropriate. MUST Screening tool is being implemented. Skin Integrity tool is being implemented.

Medication Management is referred to in Outcome 12.

Care Plans will be written up with the resident and/or his/her representative. Consent to and any restraint needs are included
See Also Outcome 8

Infection control Policy will be written up and implemented by 30 April, 2014. Remedial infection control measures will be in place by 15 April 2014 to include disposable hand towels and suitable closed lid bins in common use bathrooms. All personal linen is implemented. Deep cleaning equipment sourced and in use. Bathroom use will be rearranged by 30 April 2014 to have single gender use only. Records are being reformed to reflect the evidence.

Proposed Timescale: 30/05/2014
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that there was a planned and actual rota indicating staff on duty over a 24 hour period.

**Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
We are developing and planning two staff rotas.
1. This be the planned one which will show the planned number of staff per shift.
2. This will be completed weekly and will demonstrate the staff that were on duty per shift. Records will be maintained.

**Proposed Timescale:** 30/04/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure all of the documents and information as specified in Schedule 2 were available.

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

**Please state the actions you have taken or are planning to take:**
Personnel files will be reformed to make all evidence readily accessible. This will be completed by 30 April 2014.
Garda Vetting is in application for person in charge. Garda Vetting for all other staff is in process.

**Proposed Timescale:** 30/05/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that staff had access to appropriate training, including refresher training as part of a continuous professional development programme.
**Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**
An annual mandatory refresher and continuous professional development training programme will be drawn up by 30 May 2014. Staff training needs are reviewed at the beginning of each calendar year. Staff appraisals are annually. Records are being reformed to reflect the evidence.

**Proposed Timescale:** 30/05/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence to suggest that staff were appropriately supervised.

**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:**
Confidential personal mentoring (supervision), independent of the centre is in place for all EVS staff. Supervision for direct care senior staff is being sourced and will be in place by the 30 August 2014. Records will reflect supervisors put in place. These records will also demonstrate that the person in charge is providing regular supervision to staff.

**Proposed Timescale:** 30/08/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that all staff had copies of the Act and any regulations made under it.

**Action Required:**
Under Regulation 16 (2) (a) you are required to: Make available to staff copies of the Act and any regulations made under it.

**Please state the actions you have taken or are planning to take:**
Copies of the Act and regulations are made available to staff as at 03-04-2014. Record maintained.
We have arranged a planned information session on 22/04/2014 to talk through the regulations, act and standards with staff.

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Failing to ensure that staff were issued with any relevant guidance by statutory or professional bodies.

**Action Required:**
Under Regulation 16 (2) (c) you are required to: Make available to staff copies of relevant guidance issued from time to time by statutory and professional bodies.

**Please state the actions you have taken or are planning to take:**
Copies of relevant guidance issued from time to time by statutory and professional bodies will be made available to staff.

Records will be maintained.

| **Proposed Timescale:** 22/04/2014 |