Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004904
Centre county:	Westmeath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Maura Morgan
Lead inspector:	Jillian Connolly
Support inspector(s):	PJ Wynne; Brid McGoldrick
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
09 December 2014 10:30	09 December 2014 17:00
10 December 2014 10:30	10 December 2014 12:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

Summary of findings from this inspection

This inspection took place in two community houses which are part of a designated centre that is operated by the Health Service Executive in Westmeath. There were nine residents residing in the two houses involved in this inspection. The designated service provides services for female residents who have a diagnosis of an intellectual disability. The residents also had additional needs such as mobility needs and behaviours that challenge.

The inspection took place over two days. Inspectors met with residents and staff, reviewed documentation and observed practice. The feedback meeting involved four members of the management team.

Staff spoken to facilitated the inspection well. However inspectors found during the course of the inspection significant deficits in the safety and quality of the service provided. Ten outcomes were inspected, with nine of the outcomes resulting in major non–compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

A list of all outcomes and compliance are listed below:

Outcome 01: Residents Rights, Dignity and Consultation - Major non - compliance
Outcome 05: Social Care Needs - Major non - compliance
Outcome 06: Safe and suitable premises - Major non - compliance
Outcome 07: Health and Safety and Risk Management - Major non - compliance
Outcome 08: Safeguarding and Safety - Major non - compliance
Outcome 11: Healthcare Needs - Major non - compliance
Outcome 12: Medication Management - Moderate non -compliance
Outcome 14: Governance and Management - Major non - compliance
Outcome 16: Use of Resources - Major non - compliance
Outcome 17: Workforce - Major non - compliance

The governance and management systems were weak. While some audits were conducted, they failed to identify the failings described throughout this report. Five immediate actions were issued to the provider due to the risk in the fire management systems and in the provision of support for residents who exhibit behaviours that challenge. There were 36 breaches of regulations identified on this inspection, 24 of which are the statutory responsibility of the registered provider and 12 of which are the responsibility of the person in charge.

Due to the seriousness of the failing the inspectors undertook to take the following actions in addition to the aforementioned:
- Referral to the Fire Authority in respect of fire safety
- Weekly monitoring reports were commenced
- A meeting was held with the local health office manager in the Authority's office on 15 December 2014 and further actions agreed include:
- Provider to cease admissions
- Transfer residents that they are unable to care for
- To put in place sufficient qualified staff
- To put in place systems to monitor supervision of care and support provided to residents
- To assess all residents who require behavioural support plans

During the regulatory meeting inspectors also requested that the area manager review all of the designated centres within their remit in order to assure that the practices within all the services are effective and that residents are safe.

The action plan at the end of this report identifies the mandatory actions the provider/person in charge is required to take to ensure immediate and sustained compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

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

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector confirmed that the designated centre had a copy of the HSE policy for the management of complaints, 'Your Service Your Say.' There was also an accessible guide for residents informing them of the process involved in making a complaint which outlined the person nominated to respond to complaints on behalf of the registered provider. There was a notebook available to record complaints however there had been none recorded as of the day of inspection.

As stated in Outcome 6, the inspector confirmed that the premises in one of the houses was not fit for its stated purpose. Each resident had their own bedroom which ensured that residents had the opportunity for their privacy to be maintained. In one community house, there were two toilet/bathrooms. A communal bathroom, with a bath, shower and toilet for the use of four residents and the second, was an en suite containing a shower and toilet for the use of one resident. The inspector was informed, however that staff utilised the en suite for their own use, which is inappropriate.

The inspector observed commodes which staff confirmed were used by residents in the second community house. The inspector was informed that the commodes were utilised for two reasons, both which were as a result of the unsuitability of the premises. The first was that as the toilets consisted of three cubicles and were narrow, residents were nervous to utilise same and therefore chose to utilise a commode. Staff stated that the resident could utilise the commode in their own bedroom as they were more comfortable there. The second rationale was that the distance from the bathroom to the bedrooms of some residents was too far, particularly at night, therefore the resident preferred to utilise a commode. In all instances the residents were mobile and had the

ability to utilise standard facilities. The use of the commodes also posed a risk in respect of the management and control of infection which is detailed in Outcome 7.

Efforts had been made to ensure that residents who required accessibility aids and equipment such as wheelchairs could access areas of the house independently. For example, in one house the door saddles have been removed so that a resident could move freely between their bedroom, kitchen and bathroom. However this intervention had been omitted between the hallway and the sitting room. This restricted the access the resident had without the support of staff.

There was an absence of appropriate assessments and interventions for residents who engaged in socially inappropriate behaviour. Due to this deficit, the dignity of residents was compromised. For example, one intervention documented and implemented in a care plan was that a resident was to be removed outdoors in the event of displaying behaviours that challenge. In another instance, a resident regularly engaged in socially inappropriate behaviour which compromised their own dignity and exposed other residents to inappropriate behaviour within their home.

The inspector reviewed a sample of activity records which demonstrated that residents' access to meaningful activities was limited. None of the residents had access to a formal day service. Recreation and occupation was facilitated from their residence. An example was that in an eight day period, one resident had five drives, four walks, listened to music eight times, had gone to mass once and had music therapy twice. On review of the activity schedule for residents in a ten hour period, three half hours of the day were scheduled as non care related activities and included;

- a twice per day walk
- listening to music daily
- hand massage weekly,
- body creaming weekly
- foot spa weekly
- short drive twice per week
- music therapy weekly.

Staff informed inspectors that facilitating access to the local community was a challenge due to staffing levels, as to support one resident resulted in one staff available to support the remaining three or four residents, depending on the house.

Inspectors also observed that personal information of residents was stored in a cupboard in a communal area with no lock.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors reviewed a sample of resident's personal files and confirmed that each resident had an assessment template completed which addressed their physical, psychological and social needs. However the accuracy and effectiveness of the assessments were inconsistent. Inspectors found that the assessment template was utilised in some instances as an identification of need as opposed to an assessment of need. For example, residents who were identified as requiring support with nutrition had not been assessed utilising a validated evidence based tool to ascertain the actual risk to the resident. There were also instances where residents were identified as having challenging behaviour, however there was no evidence of a subsequent assessment. There was also a variation in the frequency in which residents had been assessed. For example, it was clear that some residents had been re-assessed annually or sooner as a result in a change of need. In other instances the date of assessment was not clear and information referenced residents' previous residence therefore not applicable to the designated centre.

Care plans had been developed for residents following an assessment or identification of need. However the quality of the plans was also inconsistent. Inspectors found that some plans of care were reflective of the individual and guided practice, while in other plans it was challenging to ascertain the actual plan of care or if the plan of care was appropriate, realistic and in line with evidence based practice. Inspectors determined that the rationale for this was a combination of poor maintenance of records and an absence of the appropriate discipline contributing to the plan of care. There was evidence that a selection of care plans had been reviewed annually or as a result of a change in need. However, there was also evidence that this had not occurred in other care plans, for example in the event of a fall, which is detailed further in Outcome 11.

Progress notes were maintained for residents, however there was not always a daily record maintained and they were not always reflective of the identified/assessed needs of residents had been met.

Access to Allied Health Professionals varied, with residents being assessed in some instances by the appropriate person such as Speech and Language Therapy. There was also evidence that referrals had been made although this was not consistent and assessment did not always occur following on from a referral.

Residents had person centre plans in place however inspectors found that there was an absence of goals both long and short term in place for residents. When goals were present they were not specific or measurable and there was no individual identified to support residents to achieve the goal. Personal centre plans were pictorial to assist in accessibility for residents and presented as life stories as opposed to plans. They had not been updated annually as required by regulations. Meetings had been conducted with the resident and/or their representatives regarding the individual needs of residents. The meetings reviewed residents' needs, however as there were no measurable goals in place, progress achieved could not be evaluated.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The designated centre consists of two community houses. The inspector determined that efforts had been made by staff to ensure that the houses were homely and personalised and reflective of the needs of residents. One of the community houses was the home to five residents, and consisted of five bedrooms, one of which was en suite, a communal bathroom, an open plan kitchen/dining room, a utility room and conservatory. Inspectors found that the house was clean and suitability decorated however a review was required of the maintenance as skirting boards were chipped and paintwork was marked. There was also a review required of the external grounds as they consisted of considerable slopes and were uneven, presenting a risk as residents in the house had a history of falls and required mobility aids such as wheelchairs. As stated in Outcome 1, a review was also required in the access residents who utilised wheelchairs had to all communal areas.

Inspectors also determined that an immediate review was required in respect of the width of the corridors due to the needs of residents and the location of fire exits which

is detailed in Outcome 7. However inspectors confirmed that there was sufficient communal and personal space for the current residents residing there.

Inspectors determined that the second house did not meet the identified needs of the four residents residing there and was in a state of disrepair. The house consists of six bedrooms, an open plan living/kitchen area, a dining room, a shower room with toilet, three cubicle style toilets, a utility room and a separate sitting room which was for the use of one resident. Four of the bedrooms were in use by residents, inspectors observed the fifth bedroom to be utilised for storage of assistive equipment and the sixth bedroom was vacant. The dining room also contained the washing machine, staff computer and documentation. As stated in Outcome 1, the location and style of the cubicle toilets impacted negatively on the dignity of residents. The shower room had tiling removed due to the removal of a bath two years previously. This matter was left unattended and in addition the floor was uneven and a risk. Paint work was in a state of disrepair. The utility room consisted of a fridge and a freezer, a dryer and a clinical waste bin which is inappropriate. Paint was flaking throughout the house and inspectors determined that the entire house required re-decoration. There was insufficient communal space for the four residents residing there. Inspectors observed that the living area and dining area could facilitate four residents. However, inspectors determined that the available communal space was insufficient based on the needs of the residents residing there due to interventions implemented for residents displaying behaviours that challenge as evidenced in Outcome 1. The inspector was informed that the provider intended to admit two additional residents into the designated centre. Inspectors informed management in the feedback meeting that this could not occur due to the insufficient communal space, insufficient storage and the disrepair of the house.

There was assistive equipment available for residents, inclusive of crash mats and hoists. There was also a raised toilet seat for a resident following assessment by an Occupational Therapist; however this was not utilised by the resident due to the toilet cubicles being too narrow. There were grab rails and ramps at fire exits however as stated in Outcome 7, there was a risk associated with same. Residents had their own beds however inspectors determined that they presented as a bed that would be associated with an acute setting as opposed to a home. There was no assessment in place to support that residents required these type of beds.

There was a decking area at the back of the house which was enclosed and secure for residents to access. However on the day of the inspection it was not accessible due to being wet and slippery as a result of the weather. This also presented a risk as it was a fire exit.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The registered provider has overarching health and safety policies and procedures and risk management policies. There was variation in the implementation, localisation and effectiveness of these policies in the designated centre. In one community house there was a risk register present however it was generic and did not reflect the actual risks present in the designated centre. For example, the ramp at the front door had no hand rails. This was not identified on the risk register. Clinical waste, food storage and laundry were located in one room. This was not identified on the risk register. Staffing had changed in recent weeks in the community house altering the skill mix. There had been a registered nurse and care assistant at night. This had changed to two care assistants at night. Residents required medication in the event of a seizure due to a diagnosis of epilepsy. The care staff had not received the appropriate training prior to this change occurring therefore were reliant on a registered nurse from another community house to administer same. The documentation stated that the medication was to be administered after five minutes. There had been no assessment of risk completed to assess if this was achievable and no evidence that this change safeguarded residents. In the second house, individual risks had been identified such as the dishwasher door being left open which was as a result of an incident which had occurred. The uneven surface at the fire exit at the back of the house had also been assessed. The control measure was escalating the risk to maintenance and management. The risk assessment was dated July 2014 and there was no evidence that action had been taken in five months, by management to mitigate the risk. There were also areas which had not been risk assessed, for example, inspectors observed the external grounds to be extremely sloped. The house was also located on a busy road with no front gates on either entrance. This had not been risk assessed.

As with the health and safety policy, the registered provider also had overarching policies in place for infection control. However improvements were required in the implementation of the policies and procedures into practice. Inspectors observed that there was sufficient hand hygiene facilities in place throughout both community houses. However there were considerable infection control risks identified by inspectors based on premises, staff knowledge and residents' needs. For example, as stated previously one room consisted of food storage, clinical waste and laundry facilities. Staff were not clear when speaking to inspectors on the appropriate infection control procedures for cleaning bodily fluids. There was also a risk associated with cross infection due to the actions of residents as a result of behaviours that challenge. In the absence of positive behaviour support, staff had attempted to identify appropriate control measures,

however inspectors determined them to be inadequate and unachievable based on the staffing in the designated centre. Commodes were also utilised in one of the community houses, as detailed in Outcome 1. However there were no facilities in place for staff to disinfect the commodes in line with best practice.

Each house had a record maintained of the servicing and maintenance of fire equipment such as the alarm, fire extinguishers and emergency lighting. Inspectors confirmed that they were serviced within the appropriate time frame. However inspectors identified numerous deficits in the fire management systems and as a result notified the statutory Fire Authority of the following failings:

•Generic Fire Plans were in place which were not reflective of the premises. For example, there was reference to stairs despite both houses being bungalows.
•Staff informed inspectors that in the event of a fire a full evacuation would be required due to an absence of fire doors
•One of the community houses had two fire exits. One which upon egress led to a ramp/stairs. The access to fire assembly is via steps, despite residents requiring support via a wheelchair to evacuate. The ramp leads to the back garden which leads to inaccessible lawn area not suitable for wheelchair users. The ramp was further obstructed with leaves and branches.
•The second community house consists of three fire exits however access to two fire exits was through the kitchen which leads to the fire assembly point in the back garden. Surfaces were uneven at both fire exits. Two residents require a wheelchair to evacuate. Fire exit through the front door leads to an unsafe environment for residents due to a lack of capacity.
•No fire drills had been conducted at either house. Staff spoken to recognised that they were unsure of what to do in the event of a fire.
•No evidence that staffing levels met the needs of residents
•Not all staff have attended annual fire lecture/training since 2012.

Inspectors issued three immediate actions to the registered provided on the day of inspection based on the risk identified. The immediate action is included at the end of this report under Regulation 28(4)(a), Regulation 28 (4)(b) and Regulation 28 (2).

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There were policies and procedures in place for the protection of vulnerable adults. Staff had also received training in the prevention, detection and response to abuse. However inspectors determined that this training had not been implemented in practice. Inspectors found incidences were residents were identified as having unexplained bruising. The bruising had been documented however there was no evidence that this had been escalated via the policies and procedures of the organisation or that the designated officer for the protection of vulnerable adults have been informed.

Inspectors also identified residents as requiring positive behaviour support however this support had not been provided. Interventions had been implemented which included:

- bringing a resident outside
- administering medication as required

These interventions were not informed by appropriate assessments and plans. There was also an absence of documented rationale for when these interventions occurred. As stated in Outcome 1, the absence of appropriate support significantly impacted on the quality of life of residents.

Staff were also scheduled to work with residents on the week of inspection who had not received training in supporting residents who engage in behaviour that is challenging.

Two immediate actions were issued to the provider in respect of provision for residents with behaviours that challenge and are included in the action plan at the end of the report under Regulation 7(2) and Regulation 7 (4).

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:

Of the sample of residents' files reviewed inspectors found that there were variations in the health care needs of residents being met. Residents had access to a general practitioner and were reviewed regularly. Residents who had been diagnosed with an acute health care need were facilitated to attend acute settings and outpatient appointments. Health promotion was in place as there was evidence that residents had been offered and administered the vaccination against Influenza. The plan of care for some residents as regards to their health care needs were informative and updated as a result of a change in need. However in other instances health care risks were not assessed and access to Allied Health Professionals was inconsistent and there was an absence of referrals in place. Two prominent areas identified were positive behaviour support and falls.

Inspectors reviewed incidences of where a resident had fallen in the previous year. Inspectors also observed the resident in question to be unsteady on their feet. The plan of care in respect of mobility created for a resident was not based on an evidence based assessment of the risk of falls, and interventions prescribed by a relevant Allied Health Professionals following the resident falling. There was no evidence of referral to the relevant Allied Health Professional. Due to an absence of an evidence based assessment tool, the care plan of the resident further omitted to address the risk of falls in the context of medication. Inspectors reviewed the prescription records of the resident and confirmed that the medications prescribed do increase the risk of falls to the resident. Inspectors observed that there was an evidence based tool in place to assess residents' who were at risk of pressure sores, however they had not been completed.

Inspectors identified one resident who had four incidences of unexplained bruising and had not been seen by a medical professional and health related rationales for the unexplained bruising had not been explored.

As stated in Outcome 7, a change in staffing had altered the skill mix within the house. However residents who had a diagnosis of epilepsy had not been risk assessed to ensure that they would receive the appropriate medical intervention within the appropriate timeframe.

There were residents who had been reviewed as regards to their nutritional needs. Inspectors found clear pathways where they had been reviewed by Speech and Language Therapist following review by the General Practitioner. The appropriate modifications had been put in place. There were also residents who had been documented as requiring high fibre diets. Inspectors spoke to staff regarding the input they had received in regards to the daily menu from a dietitian to ensure the food provided was meeting the assessed needs of residents. Staff stated that they had not received formal input and that menus had been created based on the preferences of residents. Inspectors acknowledged it is positive that residents are consulted. However the evidence did not show that the residents' nutritional needs are being met or that food provided was wholesome and nutritious as required by Regulation 18 (2)(b).

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The organisation has an overarching policy in place regarding the management of medication which addressed the generic procedures in place for the prescription, administration and safekeeping of medication. Inspectors reviewed the storage of medication in one of the community houses and was satisfied that medication was stored securely and that each medication stored had been dispensed by the pharmacist for individual residents. Each medication detailed the date it was dispensed and the expiry date. However inspectors also found medication stored in the food fridge in an unsecure location.

Residents' prescription and administration records were maintained in a booklet format. In the main, it contained all of the necessary information for the resident, including name, date of birth, address and general practitioner. The allergy section was blank on some records. Inspectors confirmed that where times of administration were documented the times correlated with the times prescribed. However in some instances the time prescribed was 'am' and 'pm'. The prescriber's signature was present for each individual medication and the maximum dosage of medication as required was present. Inspectors found that residents had been prescribed oxygen as medication as required. However there was no medical rationale recorded for same or guidance to support staff on the administration of oxygen. Of the records reviewed oxygen had not been administered and staff informed residents that it was prescribed 'just in case'. There was also an absence of guidance for staff regarding the administration of medication as required as a reactive strategy to residents exhibiting behaviours that challenge.

As stated in Outcome 11, whilst residents had regular reviews by their general practitioner and there was evidence that the pharmacist was involved in a review of residents medications, there was an absence of assessment which considered the side effects of residents' medications and the increase risk of falls.

As stated in Outcome 7, there had been a change to the skill mix in one of the community houses at night, however staff members had not received the training to administer medication prescribed for as required in the event of a seizure, as per the guidance in place for staff, prior to the change taking place.

There was no evidence of audits of medication. Staff stated that medication errors were recorded in the individual booklets of residents. During the feedback management informed inspectors that there was a specific log available for this which assists with

audits. However this policy was not implemented in practice.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that the governance and management systems in the designated centre were weak and ineffective. There were 36 breaches or regulations identified on this inspection, 24 of which are the statutory responsibility of the registered provider and 12 of which are the responsibility of the person in charge.

As stated in Outcome 1, 6, 7, 8, 16 and 17, there were numerous risks identified by inspectors which had not been identified by management:

- Absence of positive behaviour support
- Premises which were not fit for purpose
- Risk assessments had not been conducted as regards to the impact a change in staff skill mix could have on residents prior to implementation
- Unexplained bruising was not identified and escalated through the policies and procedures for the protection of vulnerable adults
- The absence of referrals to Allied Health Professionals or the delay in assessment following a referral
- The absence of induction of staff not employed in the designated centre albeit agency or staff deployed from another designated centre
- The absence of staff supervision or assessment of staff competency

There was a management system in place with the person in charge being supported by a deputy person in charge. Each house had a manager. The person in charge reports to a regional manager. The regional manager reports to a general manager who is the person identified as the provider nominee. The provider nominee reports to the area manager.

Inspectors were informed that front line managers are responsible for completing

numerous audits which are aimed at identifying that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. However due to the major non–compliance and breach of regulations identified in this report, inspectors determined that there were significant deficits in this system. Areas of risk identified by inspectors and listed above had not been previously identified by management. For example, the deficits identified regarding the absence of positive behaviour support and the resulting impact on residents had not been identified prior to this inspection. Risk assessments to ensure that the staffing levels, skill mix and knowledge of staff were appropriate to assessed needs of residents had also not occurred. Absence of person centred plans had not been identified. As stated previously, the provider outlined the intention to increase the capacity of one community house from four to six. There was no review of the premises conducted to ascertain if the premises were fit for purpose and could adequately and safely accommodate additional residents.

The number of non-compliance and the cumulative actions arising from the deficits resulted in a regulatory meeting with the area manager, acting general manager and regional manager on 15th December 2014 in the Authority's office.

Judgment:
Non Compliant - Major

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

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that the designated centre was not adequately resourced to meet the needs of residents. Evidence did not support that the staff skill mix and staff competency was appropriate to meet the needs of residents. As stated in Outcome 1 and 8, there was a significant delay from referral to assessment by Allied Health Professionals for residents requiring positive behaviour support which further demonstrated the inadequate resources. The lack of sufficient resources which resulted in residents not having opportunities for engagement in meaningful activities was as a result of staff knowledge and staffing levels. For example, inspectors viewed documentation that one resident should 'ideally' have two staff present when exhibiting behaviours that challenge however as there were only two staff on duty, if a staff member was supporting another resident this could not occur.

Judgment:

Non Compliant - Major

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

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors reviewed the rosters in the houses and confirmed that the staffing levels on the day of inspection were reflective of the general roster. In one community house the standard staffing level was one staff nurse and one care assistant from 8.00 hours to 20.00 hours and two care staff from 20.00 hours to 8.00 hours. In the second community house the standard staffing level was one staff nurse and one care assistant from 8.00 hours to 20.00 hours and one care staff from 20.00hours to 8.00 hours. At night, there was one staff nurse shared between this community house and another house which was not part of the designated centre. Inspectors queried the rationale for where the nurse was located and was informed by staff that it was generally the house that they were employed to work in and would attend the second house to administer medication. However the nurse would remain in the second house if the need was greater on the night. There was no risk assessment in place considering that residents had been prescribed oxygen as required, and care staff had not had the training in the administration of same. As stated previously, a risk assessment had not been completed for a change in the skill mix of staff in the other community house.

On the day of inspection, there was a staff member in each house who were not permanently involved in the care of the residents in the house. One member of staff was an agency staff and the second staff was deployed from another house. Inspectors found that whilst the staff attempted to facilitate the inspection, they were not confident in the working of day to day operations of the house. There was no formal induction plan in place and they did not have the relevant knowledge to support the residents.

Staff training was also inadequate to meet the needs of residents; the following had not been completed by all staff:
- Fire training annually
- Positive behaviour support, de-escalation and crisis intervention training
- Administration of oxygen
- Medication as required in the event of a seizure

Based on the failings of this inspection, Inspectors determined that additional training was also required in the following:

• Manual Handling particularly for mobile residents who were at risk of falls
• Infection Control including HACCAP training for relevant staff
• Assessment and Care Planning
• Nutrition
• Risk Identification and Management

There was also no staff supervision in place or assessment of competency of staff.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004904
Date of Inspection:	09 and 10 December 2014
Date of response:	26 March 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents privacy and dignity was compromised by:
- staff utilising the en suite of a resident
- the use of commodes due to premises not meeting their stated purpose
- personal information not being securely stored

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

Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
1. All staff in the designated centre where instructed that the toilets in each of the 2 houses were specifically for the use of residents were not to be used by staff for their own use. All staff in each of the houses in the designated centre have ceased using the toilets in their own use with Immediate effect.

2. In one bathroom work has been completed to make the toilet accessible for the use of residents living there. Tiling was replaced where a bath had been removed and the lino was removed and replaced on the floor.

3. The second bathroom in one of the houses was assessed by the Occupational Therapist and Physiotherapist and measures were put in place to make it safe to use. Presses where removed and a mirror on the wall. A further Assessment was completed by the Occupational Therapy and Physiotherapy in relation to the second bathroom. Recommendations were made. A specification of users has been drawn up to remove a dividing wall and convert the three cubicles into one accessible toilet. Toilet doors were replaced to open outwards with immediate effect and privacy locks were placed on the toilet doors.

4. One resident who was using a commode in their bedroom has been assessed by the Occupational Therapist and the Physiotherapist. A Mobility Plan has been put in place to facilitate the resident to access the toilet facility with the appropriate equipment. This resident has had an updated care plan for their mobility and personal care.

5. Handrails will be provided in the designated centre to improve accessibility for residents with restricted mobility. The provision of handrails is included in the Bill of Quantity. This has gone to Tender.

6. In the second house the door saddles which restricted one resident mobilising around the house were removed.

7. One resident requiring behavioural intervention was reviewed by the Psychologist and staff working in behavioural therapy. A reactive strategy and protocol on the use of restrictive intervention is currently in place.

8. All Personal Information has been securely stored in the designated centre. A lock was placed on the press containing residents Personal Information in the house identified.

Proposed Timescale:
1. 31/01/2015

2. 31/01/2015
3. 31/01/2015
4. 31/01/2015
5. 31/01/2015
6. 31/01/2015
7. 23/12/2014
8. 31/01/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have the opportunity to engage in activities which were meaningful to them.

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

Please state the actions you have taken or are planning to take:
Each house has reviewed each individual's access to meaningful activities and a weekly activity plan has been implemented for each resident. One resident has obtained a Day Service in a local Resource Centre. Another resident has accessed a Community Day Service. A referral was sent for another resident to access a local Resource service. A review of supports required to facilitate meaningful activity plans in each house was conducted by the Clinical Nurse Manager of the house. The purpose of this review was to identify the additional support requirement necessary to implement the plans in the houses.

Proposed Timescale: 31/01/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the absence of the following:
-appropriate assessment
- plans of care developed by the appropriate discipline
-interventions and staff training
- evaluations of effectiveness of above
residents were not provided with the appropriate care and support required to meet their needs.

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

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

1. Staff trained in Behaviour Therapy have carried out assessments and have put the appropriate interventions and strategies in place in the administration of PRN medication and behaviour support plans in the designated centres.

2. The Clinical Psychologist will review the residents who were experiencing behaviours of concern.

3. A schedule of monthly reviews by the behaviour support team has been established to review and evaluate behaviour support plans in the designated centre. The first Behaviour support review of this Governance group will commence on 26/02/2015.

4. Another resident requiring behavioural intervention was reviewed on 16/10/2014 by the psychologist and by staff working in behavioural therapy. A reactive strategy and Protocol on Restrictive interventions was been drawn up on 23/12/2014 in relation to the supports identified. A process has commenced to implement positive behaviour support plans for both individuals. Data collection has commenced. All Behaviour Support plans will be updated in the designated centre.

5. All staff will receive Training in the Management of Behaviours of concern. A schedule for staff Training was drawn up by staff trained in Behaviour Support. Staff Trained in Behaviour support will deliver the Training in the Management of Behaviours to staff in the designated centre.

Proposed Timescale:
1. 31/12/2014
2. 31/12/2014
3. 26/02/2015
4. 28/02/2015
5. 28/02/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessments conducted were inconsistent and not evidence based.

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:
1. All residents in the designated centre identified as requiring a nutritional assessment have been assessed using the MUST Assessment Tool.

2. All staff will receive training in documentation and record keeping in the designated

centre. This training will be facilitated by the NMPDU and administered by the Nurse Practice Development Coordinator on 10/02/2015. Further training will be scheduled in record keeping and documentation by the Centre for Nurse Education in April 2015.

3. Each resident's Person Centred Plan will be reviewed and updated to reflect identified long and short term goals.

4. Each Person Centred Plan will be reviewed to identify short and long term goals. A key worker system has been put into effect in each of the houses. The key worker is responsible for reviewing the effectiveness of the Person Centred Plan.

Proposed Timescale:
1. 31/01/2015
2. 10/02/2015
3. 31/12/2014
4. 31/12/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Plans of care did not consistently outline the necessary supports required to meet the identified/assessed needs of residents.

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

Please state the actions you have taken or are planning to take:
1. Each resident's Person Centred Plan will be reviewed and updated to reflect identified long and short term goals.

2. All care plans in the designated centres will be reviewed and updated to identify the assessed needs and supports of the residents.

Proposed Timescale: 31/12/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews of personal plans were not multi-disciplinary.

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:
All residents will have their plans reviewed by the Multi disciplinary Team. A schedule for a forum for monthly reviews by the Multi Disciplinary Team has been developed for the service. The first MDT forum has taken place on the 03/02/2015.One resident had their Personal Plan reviewed at the Multidisciplinary Team Meeting on 03/02/2015.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not consistently reviewed and did not take in effectiveness as:
- there was an absence of measurable goals
- progress notes were not reflective of assessment

Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
1. Each resident's Person Centred Plan will be reviewed and updated to reflect identified long and short term goals.

2. A schedule for a forum for monthly reviews by the Multi Disciplinary Team has been developed for the service. The first MDT forum has taken place on the 3rd February 2015.

3. Each Person Centred Plan has been reviewed to identify short and long term goals. A key worker system has been put into effect in each of the houses. The key worker is responsible for reviewing the effectiveness of the Person Centred Plan with the Service User they support.

Proposed Timescale:
1. 31/12/2014
2. 03/02/2015
3. 31/12/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors determined that one of the community houses was not fit for meeting the identified needs of residents. A review was also required of the external grounds in both houses.

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:
1. The Occupational Therapist has carried out an assessment in relation to the width of the corridors in both houses. Recommendations have been made to improve accessibility. A Bill of quantity has been prepared and is gone to Tender for the completion of the recommendations of the Occupational Therapist.

2. A review was carried out by the Fire Officer with immediate effect. The Fire Officer visited the designated centre on 10/12/2014 and issued recommendations on the needs of the residents with regard to Fire Safety and access to the fire exits.

3. The decking area outside of the house has been cleared of leaves and cleaned with immediate effect.

4. There is a plan in place to extend the fire exit at the back of one house to the front of the building. A pathway is being created to the fire assembly point where there was previously uneven grass land. A Bill of Quantity for work identified to rectify this is complete and has gone to Tender.

5. In one of the houses a Risk assessment was carried out in relation to the road at the front of the house in the event of a fire evacuation to the front of the house. A high risk was identified due to the proximity of the road. A Bill of Quantity for work identified to rectify this is complete and has gone to Tender.This includes the following:

• Install a new pedestrian access footpath (to detail) from end of existing disabled ramp to existing tarmacadam surfacing (front of building).
• ELECTRICAL Install new electrical lights, emergency lighting, remote indicators, GEZE easy free door closing devices, c.w. power supplies as per drawing (includes fire alarm systems and commissioning by HSE approved contractor)
• Supply & Install new FD 30s with associated ironmongery.
• Install a limestone clad disabled ramp to front of house over existing tarmacadam surfacing (front of building).
• Build back front piers and adjacent wall in a similar brick. Install 2no pairs of gates to each entrance, to detail provided in M/S galvanised.

Proposed Timescale:
1. 31/01/2015
2. 10/12/2014
3. 19/12/2014
4. 31/03/2015
5. 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One of the community houses was in a state of disrepair as stated in Outcome 6.

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:
1. In one bathroom work has been completed to make the toilet accessible for the use of residents living there. Tiling was replaced where a bath had been removed and the lino was removed and replaced on the floor.

2. The second bathroom in one of the houses was assessed by the Occupational Therapist and Physiotherapist and measures were put in place to make it safe to use on 23/01/2015. Presses and a mirror on the wall were removed. Toilet doors were replaced to open outwards with immediate effect and privacy locks were placed on the toilet doors.

3. A further Assessment was completed by the Occupational Therapist and Physiotherapist in relation to the second bathroom. Recommendations were made. A Bill of Quantity has been drawn up to remove a dividing wall and convert the three cubicles into one accessible toilet.

• New alterations/ renovation works to Toilet areas including associated sewer connections and external works, sanitary ware/grab rails, and new coved floor finishes.

4. The fridge which was stored in the laundry room in both houses has been moved from the utility area to the kitchen with immediate effect.

5. The washing machine which was stored in the kitchen area in one of the houses has been moved to the utility room with immediate effect.

6. The bin containing clinical waste has been removed from the utility room with immediate effect.

7. There is a plan in place to extend the fire exit at the back of one house to the front of the building. A pathway is being created to the fire assembly point where there was previously uneven grass land. A Bill of Quantity for work identified to rectify this is complete and has gone to Tender. This includes the following:

• Install a new pedestrian access footpath (to detail) from end of existing disabled ramp to existing tarmacadam surfacing (front of building).
• Install a limestone clad disabled ramp to front of house over existing tarmacadam surfacing (front of building).

8. Painting and decoration of both houses will be commenced. A Bill of Quantity has been prepared and has gone to Tender.

9. The Occupational Therapist has carried out an assessment in relation to the width of the corridors in both houses. Recommendations have been made to improve accessibility. A Bill of quantity has been prepared and is gone to Tender for the completion of the recommendations of the Occupational Therapist.

10. Provision will be made for storage of assistive equipment to allow for the use of additional space in the designated centre.

11. One resident has been identified as requiring a hospital bed in one of the houses. New beds will be purchased for the remaining residents currently residing in one of the houses.

12. There is a plan in place to move from one of the houses into new residence. Permission has been sought and approved. Tenders were sought and returned. The proposed start date is March 17th 2015 and the proposed date for completion is September 2016.

Proposed Timescale:
1. 31/01/2015
2. 31/01/2015
3. 31/03/2015
4. 31/01/2015
5. 31/01/2015
6. 10/12/2014
7. 31/03/2015
8. 31/03/2015
9. 31/03/2015
10. 28/02/2015
11. 28/02/2015
12. 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Both houses required a reviewed of decoration due to paint flaking and numerous marks on paint work.

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:
There is a plan in place to paint the corridors and bedrooms in both of the houses in the designated centre. This is included in a Bill of Quantity. This has gone to Tender .It includes the following:

• Build up hatch in Kitchen/ Dining Room wall finish + paint. Alteration works to wardrobe in Dining Room

• Painting & Decoration as per schedule + specification.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' beds were those associated with an acute setting without a rationale or assessment of same.

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

Please state the actions you have taken or are planning to take:
1. One resident has been assessed by an Occupational Therapist and Physiotherapist and identified as requiring a hospital bed in one of the houses.

2. Three new beds will be sourced for two residents currently residing in the house. They are in the process of being purchased. This will be completed by 28/02/2015.

Proposed Timescale: 28/02/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review was required to ensure that residents could exit and egress all areas of the designated centre without undue support from staff.

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:
1. A door Saddle has been removed from the doorways in one of the houses to facilitate a resident with a wheelchair living in the house to access all areas within the house. The remaining saddles will be removed. A Bill of Quantity of works has been completed and has gone to Tender.

2. An Assessment was carried out in one of the houses by an Occupational Therapist and Physiotherapist on accessibility. There is a plan to place handrails in the bathroom and on the corridors. A Bill of Quantity has been drawn up and has gone to Tender.

3. The Occupational Therapists recommendations are been implemented to make the second Bathroom in one of the houses accessible. A Bill of Quantity of works has been drawn up and is gone to Tender. This will be completed by 31/03/2015.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The following deficits were identified by inspectors which evidenced that the requirements of Schedule 6 were not being met:
- insufficient storage
- insufficient communal space
- inappropriate toilet facilities

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:
1. Provisions have been made to increase communal space. Storage of assistive equipment which is not in use will be facilitated in a designated end room in one of the houses. Two bathrooms in one of the houses have been assessed by the Occupational Therapist and Physiotherapist and recommendations have been implemented. In one bathroom, the tiling was replaced on the wall and the lino was removed and replaced. A mirror and some items which were in close proximity to the toilet were removed from the wall. The toilet doors in the narrow cubicles were removed and replaced to open outward and privacy locks were placed on the cubicle doors. A large press on the Toilet entrance wall was removed. Handrails are being installed and the sink is being moved. A Bill of Quantity has been prepared and has gone to Tender to address the issues with the bathroom.

2. A Bill of Quantity of works to modify the bathroom with the 3 cubicles has been drawn up and has gone to Tender. This will be completed by 31/03/2015. The works include the widening of the cubicles and increase of space to make the toilet accessible for the residents.

3. There is a plan in place to move from one of the houses into new residence. Planning Permission has been sought and approved. Tenders were sought and returned. The proposed start date is March 17th 2015 and the proposed date for completion is September 2016.

Proposed Timescale:
1. 28/02/2015
2. 31/01/2015
3. 30/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inconsistency in the assessment of risk in the designated centre.

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:
1. In one of the houses a risk assessment was carried out in relation to the road at the front of the house in the event of a fire evacuation to the front of the house. A high risk was identified due to the proximity of the road. There is a plan in place to place a gate at the entrances to the front of the house. This is included in the Bill of Quantity. This has gone to Tender.

2. A Risk Assessment was carried out in relation to fire and staffing levels in both houses. Following a risk assessment and an assessment of need a nurse was placed on night duty from 20.00hrs to 08.00hrs in one of the houses. This addresses the requirement for residents requiring rescue medication for Epilepsy Management.

3. The Risk in relation to access to General Fire Safety, Fire Exits during Fire Evacuation and falls due to the absence of a pathway in one of the houses and uneven surface in the other house is being addressed. A Bill of Quantity was drawn up in relation to the work required and has gone to Tender. This includes the following:
• Install a new pedestrian access footpath (to detail) from end of existing disabled ramp to existing tarmacadam surfacing (front of building).
• Supply & Install new FD 30s with associated ironmongery
• ELECTRICAL Install new electrical lights, emergency lighting, remote indicators, GEZE easy free door closing devices, c.w. power supplies as per drawing (includes fire alarm systems and commissioning by HSE approved contractor)
• Carpentry and joinery -installation of new fire rated attic hatch
• Install wall buffers behind beds to each Bedroom to detail
• Install a limestone clad disabled ramp to front of house over existing tarmacadam surfacing (front of building). See drawings and specifications.
• Build back front piers and adjacent wall in a similar brick. Install 2no pairs of gates to each entrance, to detail provided in M/S galvanised.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Identified control measures had not been implemented to mitigate risk.

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

Please state the actions you have taken or are planning to take:
1. In one of the houses a risk assessment was carried out in relation to the road at the front of the house in the event of a fire evacuation to the front of the house. A high risk was identified due to the proximity of the road. There is a plan in place to place a gate at the entrances to the front of the house.

2. A Risk Assessment was carried out in relation to fire and staffing levels in both houses. A nurse was placed on night duty from 20.00hrs to 08.00hrs in one of the houses.

3. In the other house a risk assessment was carried out in relation to the fire Exits and the ramps in both houses of the house leading to the Fire assembly point. A high risk was identified due to the mobility needs of the residents. The issues of concern were identified. The uneven surfaces were levelled with immediate effect. The provision of a pathway and ramp is included in a Bill of Quantity which has gone to Tender.

4. Training on Risk Management will be provided for all staff in the designated centre. All Managers in the designated centres will receive Training in Risk Management. Training was provided on 08/01/2015. 12 staff received Training. The person responsible for providing the Training is the Healthcare Risk Manager.

Proposed Timescale:
1. 31/03/2015
2. 31/01/2015
3. 31/03/2015
4. 28/02/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management and control of infection was inadequate due to:
- the use of commodes
- absence of appropriate supports for residents who experience behaviours that challenge
- the training and knowledge of staff

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:

1. Staff trained in Behaviour Therapy have carried out assessments and have put the appropriate interventions and strategies in place in the administration of PRN medication and managing behaviours of concern in the designated centres.

2. The Clinical Psychologist has reviewed the residents who were experiencing behaviours of concern. A schedule of monthly reviews by the behaviour support team has been established to review and evaluate behaviour support plans in the designated centre.

3. Another resident requiring behavioural intervention was reviewed by the psychologist and by staff working in behavioural therapy. A reactive strategy has been drawn up in relation to the behaviours identified and a process has commenced to implement a positive behaviour support plan.

4. All staff in the designated centre will receive Training in Hand Hygiene and Infection prevention and control. This Training was delivered by the Midlands Infection Prevention and control Team.12 staff received Training on13/01/2015 and 1 staff received Training on 22/11/2014.Further Training is in the process of being scheduled.

5. All staff will receive Training in Crisis Prevention Intervention. 5 staff in one of the houses centre attended Training. 1 staff member was Trained in CPI on each the following dates 17/12/2014, 05/12/2014, 09/12/2014, 02/12/2014 and 29/01/2015. In the second house 6 staff received Training in Crisis Prevention Intervention on 16/12/2014 and 1 staff member received Training on 26/01/2015.

6. All staff in the designated centre will receive HACCAP Training. HACCAP Training is in the process of being sourced for the designated centre.

7. The practice of using commodes in bedrooms has discontinued with immediate effect. Service Users who previously used commodes in their bedrooms have been assessed by the Physiotherapist and Occupational Therapist and have the recommended Equipment to facilitate access to the bathroom.

8. An Audit will be conducted on Infection control practice in the Designated Centre. The Audit Tool has been drawn up by the Infection control Team in the Midlands. The Audit will be conducted by the Assistant Director of Nursing and the Regional Director of Nursing.

9. All staff will receive Training in Oxygen Administration.

Proposed Timescale:
1. 31/12/2014
2. 31/12/2014
3. 31/12/2014
4. 28/02/2015
5. 28/02/2015
6. 30/04/2015
7. 28/02/2015

8. 30/04/2015
9. 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
On inspection, there was evidence that not all staff rostered to work on week beginning the 7 December 2014 had received fire training annually. There was further evidence that as fire training occurs outside of the designated centre staff were not familiar with the evacuation arrangements due to the building layout and the assessed needs of the residents.

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:
1. All staff in the designated centre will receive Fire Training. The Fire Officer conducted Training onsite in each of the designated centres. In one of the houses 9 staff received Training in Fire Safety on 02/02/2015 and 1 staff on 19/12/2014.In the second house 2 staff attended training on Fire Training on 22/12/2014 and 3 staff attended Fire Training on 03/01/2015 and 02/02/2015.

2. A Fire Evacuation plan has been drawn up in each of the houses.

3. Each of the designated centres will have regular fire drills. All managers in each of the areas have been given a schedule to record the details of the fire drills.Fire drills commenced in each of the houses with immediate effect.

4. The Fire Officer attended each of the houses on 10/12/2014 to look at the Fire Safety Measures in place. He issued recommendations which were issued to maintenance for Implementation on 12/12/2014.

5. An Independent Review of Fire Prevention and control was conducted in both areas in October 2014.

6. A Meeting was scheduled with the Maintenance Manager for HSE Estates on 12/12/2014 to address and works which are required.

7. The uneven surfaces on each of the ramps will be filled by week ending 19/12/2014.

8. A new Assembly Point in one of the houses has been identified to the left of the rear garden.

Proposed Timescale:
1. 28/02/2015

2. 31/12/2014
3. 31/12/2014
4. 12/12/2014
5. 12/12/2014
6. 12/12/2014
7. 12/12/2014
8. 12/12/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There had been no fire drills conducted as of the 9 December 2014 in either premises.

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:
Each of the designated centres will have regular Fire Drills All managers in each of the areas have been given a schedule to record the details of the fire drills.Fire drills commenced in each of the houses with immediate effect.

Proposed Timescale: 12/12/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One of the community houses had two fire exits. One which upon egress led to a ramp/stairs. The access to fire assembly is via steps, despite residents requiring support via a wheelchair to evacuate. The ramp leads to the back garden which leads to dead end. The ramp was further obstructed with leaves and branches.
The second community house consists of three fire exits however access to two fire exits was through the kitchen which leads to the fire assembly point in the back garden. Surfaces were uneven at both fire exits. Two residents require a wheelchair to evacuate. Fire exit through the front door leads to an unsafe environment for residents.

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:
1. A Bill of Quantity of works has been drawn up to provide a concrete pathway over the grass to the front of the building from the rear exit in one of the houses.

2. The ramp has been cleared to remove the leaves and branches with immediate effect.

3. Uneven Surfaces at both exists in the second house have been repaired with immediate effect.

4. A risk assessment was completed identifying the risk associated evacuating to the front door of one of the houses and gates are being sourced to secure the gateway leading to the road. A Bill of Quantity was prepared and has gone to Tender.

Proposed Timescale:
1. 31/03/2015
2. 12/12/2014
3. 12/12/2014
4. 31/03/2015

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:
Staff are scheduled to work with residents on the week beginning 7 December 2014 who had not received training in supporting residents who engage in behaviour that is challenging.

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

Please state the actions you have taken or are planning to take:
1. Staff trained in Behaviour Therapy have carried out assessments and have put the appropriate interventions and strategies and Behaviour support plans in place in the designated centre.

2. A schedule of monthly reviews by the behaviour support team has been established to review and evaluate behaviour support plans in the designated centre. The first Behaviour support review of this Governance group will commence on 26/02/2015.

3. A resident requiring behavioural intervention was reviewed on 15/12/2014 by the psychologist and by staff working in behavioural therapy. A reactive strategy and Protocol on Restrictive interventions was been drawn up on 23/12/2014 in relation to the supports identified .A process has commenced to implement positive behaviour support plans for both individuals. Data collection has commenced. All Behaviour Support plans will be updated in the designated centre.

4. All staff will receive Training in the Management of Behaviours of concern. A schedule for staff Training was drawn up by staff trained in Behaviour Support. Staff Trained in Behaviour support will deliver the Training in the Management of Behaviours to staff in the designated centre. Training sessions will be conducted on 10/02/2014 and 24/02/2015.2 staff are attending a 2 day BUILD Training course on "Positive

Behaviour Support a Human Rights Perspective ",on 07/05/2015 and 08/05/2015.

5. All staff will receive Training in Crisis Prevention Intervention. 5 staff in one of the houses centre attended Training. 1 staff member was Trained in CPI on each the following dates 17/12/2014, 05/12/2014, 09/12/2014, 02/12/2014 and 29/01/2015. In the second house 6 staff received Training in Crisis Prevention Intervention on 16/12/2014 and 1 staff member received Training on 26/01/2015

Proposed Timescale:
1. 15/12/2014
2. 26/02/2015
3. 23/12/2014
4. 10/02/2015 and 08/05/2015.
5. 28/02/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Interventions were implemented in response to residents displaying behaviours that challenge without any documented guidance or rationale for the action taken.

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:
1. A resident identified as requiring behavioural intervention was reviewed on 16/10/2014 by the psychologist and by staff working in behavioural therapy. A reactive strategy and Protocol on Restrictive interventions was drawn up on 23/12/2014 in relation to the supports identified.

2. Staff trained in Behaviour Therapy have carried out assessments and have put the appropriate interventions and strategies in place in the administration of chemical Restraint and behaviour support plans in the designated centres.

3. All staff will receive Education on the Policy on the use of Restrictive Interventions. This will be provided by the Clinical Nurse Manager of the Service in conjunction with staff qualified in Behaviour Support.

Proposed Timescale:
1. 23/12/2014
2. 23/12/2014
3. 28/02/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Inspectors identified one resident who had four incidents of unexplained bruising.

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:
1. All staff will receive Training on the Protection of vulnerable adults.

2. All staff will be aware of the procedure to follow in the event that a resident has unexplained bruising. The Manager of each house will facilitate Training for staff on the Abuse Policy.

Proposed Timescale:
1. 31/12/2014
2. 31/12/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Incidents of unexplained bruising had not been investigated.

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

Please state the actions you have taken or are planning to take:
An immediate Investigation was implemented in relation to unexplained Bruising. A Preliminary Screening was conducted on 10/12/2014 by 2 designated officers and a full Report with recommendations were Issued to the Regional Director from the Investigating Team. The recommendations of the designated Officers have been implemented.

Proposed Timescale: 28/02/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inconsistency on the health care provided to residents based on:
- an absence of evidence based tools to assess the actual level of health care risk to residents
- An absence of investigation or review following incidents such as unexplained bruising
- An absence of appropriate monitoring and supervision of residents who sustained falls
- An absence of appropriate care for residents who exhibited bahaviours that challenges

- An absence of assessment of the suitability and competency of staff skill mix

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

Please state the actions you have taken or are planning to take:
1. An immediate Investigation was conducted by 2 designated officers in relation to unexplained Bruising. A Preliminary Screening was conducted on 10/12/2014 and a full Report with recommendations were Issued to the Regional Director from the Investigating Team. The recommendations of the Designated Officers have been followed up.

2. An Individual Service User who was identified as having a risk of falls was reviewed by the Occupational Therapist and the Physiotherapist and a falls risk assessment and Mobility Care plan has been implemented with the recommendations of the Physiotherapist and Occupational Therapist with immediate effect.

3. One Individual resident in the house requiring behavioural intervention was reviewed on 15/12/2014 by the psychologist and by staff working in behavioural therapy. A reactive strategy and Protocol on Restrictive interventions was been drawn up on 23/12/2014 in relation to the supports identified .A process has commenced to implement positive behaviour support plans for both individuals identified as having Behaviours of concern. Data collection has commenced. All Behaviour Support plans will be updated in the designated centre.

4. A Risk Assessment was carried out in relation to fire and staffing levels in both houses. Following a risk assessment and an assessment of need A Registered Nurse was placed on night duty from 20.00hrs to 08.00hrs in one of the houses. This addresses the requirement for residents requiring rescue medication for Epilepsy Management

5. All residents in the designated centre will be assessed using the MUST Tool.

Proposed Timescale: 28/02/2015
1. 28/02/2015
2. 31/01/2015
3. 31/12/2014
4. 31/01/2015
5. 31/01/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Access to Allied Health Professionals was inconsistent

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:
1. All staff in the designated centre will seek access to allied health professionals where their input is required to inform the residents care plan.

2. 2 Staff Members qualified in Behaviour Support have been provided from the Service to provide services in updating and reviewing the Behaviour Support Plans in the Houses.

Proposed Timescale:
1. 31/12/2014
2. 15/12/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Food was stored alongside clinical waste and laundry facilities

Action Required:
Under Regulation 18 (1) (b) you are required to: Ensure there is adequate provision, so far as reasonable and practicable, for residents to store food in hygienic conditions.

Please state the actions you have taken or are planning to take:
1. All Staff will ensure correct storage requirements are adhered to in relation to food and clinical waste. The fridge has been moved from the Utility room to the Kitchen area. The clinical waste bin has been removed.

2. All staff in the designated centre will receive Training in Hand Hygiene and Infection prevention and control. This Training was delivered by the Midlands Infection Prevention and control Team.12 staff received Training on13/01/2015 and 1 staff received Training on 22/11/2014.

Proposed Timescale:
1. 31/01/2015
2. 28/02/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was in sufficient evidence to support the nutritious value of food

Action Required:
Under Regulation 18 (2) (b) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

Please state the actions you have taken or are planning to take:
The Clinical Nurse Manager in each of the houses will review the diet of residents with a Dietician in the designated centre to ensure that they are receiving a balanced and nutritious diet.

Proposed Timescale: 28/02/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication was stored unsecurely in a food refrigerator.

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:
1. The Medication has been removed from the food refrigerator.

2. A clinical fridge will provided for each of the houses for the storage of medicines. Quotations have been obtained. A fridge suitable to the needs of the houses has been identified and is in the process of being purchased.

Proposed Timescale:
1. 31/01/2015
2. 28/02/2015

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:
Based on the significant failings identified on this inspection, inspector determined that the management systems were ineffective and did not ensure safe and quality services for 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:
1. A Plan is in place for all Managers to be the Person in Charge of their Houses. The

Clinical Nurse Managers in each of the houses have submitted their details for Person in Charge on 06/02/2015.

2. Training will be provided in the designated centre for all Persons in charge on their role. This Training will be provided by the Nurse Practice Development coordinator in the Nursing and Midwifery and Planning Unit.

3. An Implementation group meets weekly to Implement and monitor the Actions required in the Service.

4. The Assistant Director of Nursing will review all reports for the houses and will visit the designated centre weekly to ensure that the Service is safe, appropriate to resident's needs and effectively monitored.

5. A forum has commenced for weekly Meetings with Clinical Nurse Managers, the Director of Nursing and Assistant Director of Nursing to take place. This forum provides Clinical Governance through addressing Quality Issues in practice, Improving practice and Care for Service Users, supporting and promoting learning for Clinical Managers.

Proposed Timescale:
1. 12/02/2015
2. 28/02/2015
3. 16/12/2014
4. 31/12/2014
5. 16/12/2014

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the safety and quality of care provided.

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

Please state the actions you have taken or are planning to take:
1. Staff qualified in Behaviour support have been provided to support staff to develop behaviour supports for residents in the designated centre. A schedule for a monthly review of behaviour supports across the service behaviour governance team has been implemented the first review is scheduled for 26/02/2015.

2. All residents will have their plans reviewed by the Multi disciplinary Team. A schedule for a forum for monthly reviews by the Multi Disciplinary Team has been developed for the service. The first MDT forum has taken place on the 03/02/2015.One resident had their Personal Plan reviewed at the Multidisciplinary Team Meeting on 03/02/2015.

3. An Independent Audit System will be identified to ensure Safety and ongoing Quality

of care is provided in the designated centre. The Nurse Practice Development Coordinator will provide an Independent Audit Tool which will be implemented in the Service.

Proposed Timescale:
1. 31/12/2014
2. 31/12/2014
3. 28/02/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors determined that the designated centre was not resourced effectively as: -
- Evidence did not support that the staff skill mix and staff competency was appropriate to meet the needs of residents
- There was a significant delay from referral to assessment by Allied Health Professionals for residents requiring positive behaviour support

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

Please state the actions you have taken or are planning to take:
1. A Risk Assessment was carried out in relation to fire and staffing levels in both houses. Following a risk assessment and an assessment of need A Registered Nurse was placed on night duty from 20.00hrs to 08.00hrs in one of the houses. This addressed the requirement for residents requiring rescue medication for Epilepsy Management.

2. Staff trained in Behaviour Therapy have carried out assessments and have put in place interventions and strategies for the administration of PRN medication and behaviour support plans in the designated centres.

3. The Clinical Psychologist has reviewed the residents who were experiencing behaviours of concern.

4. A schedule of monthly reviews by the behaviour support team has been established to review and evaluate behaviour support plans in the designated centre. The first Behaviour support review of this Governance group will commence on 26/02/2015.

5. An Individual resident requiring behavioural intervention was reviewed on 15/12/2014 by the psychologist and by staff working in behavioural therapy. A reactive strategy and Protocol on Restrictive interventions was been drawn up on 23/12/2014 in relation to the supports identified .A process has commenced to implement positive behaviour support plans for both individuals identified as requiring Behaviour Support.

Data collection has commenced. All Behaviour Support plans will be updated in the designated centre.

6. All staff will receive Training in the Management of Behaviours of concern. A schedule for staff Training was drawn up by staff trained in Behaviour Support. Staff Trained in Behaviour support will deliver the Training in the Management of Behaviours to staff in the designated centre. Training sessions are scheduled for 10/02/2015 and 24/02/2015.

Proposed Timescale:
1. 31/01/2015
2. 23/12/2014
3. 15/12/2014
4. 26/02/2015
5. 31/12/2015
6. 28/02/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of risk assessments to evidence that the staffing levels and skill mix were appropriate to meet the 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:
1. A Risk Assessment was carried out in relation to fire and staffing levels in both houses. Following a risk assessment and an assessment of need A Registered Nurse was placed on night duty from 20.00hrs to 08.00hrs in one of the houses. This addresses the requirement for residents requiring rescue medication for Epilepsy Management

2. Each house will have a review of the dependency level of the residents and staff skill mix. A dependency Tool has been sourced and reviews of residents dependency levels will be completed in the designated centre.

Proposed Timescale:
1. 31/01/2015
2. 31/03/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Due to inadequacies in care and inconsistencies in plans of care and nursing notes, inspectors were not assured that nursing care was being provided in line with evidence based practice.

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:
All staff will receive Training on Making Evidence based Practice a Reality. This Training will be provided by the Nurse Practice Development Officer in the National Planning and Development Unit.

Proposed Timescale: 28/02/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that agency staff and staff deployed from other designated centres had the necessary knowledge to provide safe and effective services for residents.

Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
An induction checklist for each house will be put in place for new agency staff working in the designated centre.

Proposed Timescale: 31/12/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As stated in Outcome 17, staff did not have the necessary training to adequately support residents.

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:

1. All staff in the designated centre will receive Training in Hand Hygiene and Infection prevention and control. This Training was delivered by the Midlands Infection Prevention and control Team.12 staff received Training on13/01/2015 and 1 staff received Training on 22/11/2014.

2. All staff in the designated centre will receive Training in Epilepsy Management. This Training will be delivered by staff Trained in Epilepsy Management. To date 10 staff have received training in the Management of Epilepsy: 5 staff received Training in the designated centre on 02/12/2014, 1 staff received Training on the each of following dates26/11/2014, on 21/12/2014, and on 09/12/2014 and 2 staff received Training on 17/12/2014.

3. All staff in the designated centre will receive Fire Training. The Fire Officer conducted Training onsite in each of the designated centres. In one of the houses 9 staff received Training in Fire Safety on 02/02/2015 and 1 staff on 19/12/2014.In the second house 2 staff attended training on Fire Training on 22/12/2014 and 3 staff attended Fire Training on 03/01/2015 and 02/02/2015.

4. All staff will receive Training in Crisis Prevention Intervention. 5 staff in one of the houses centre attended Training. 1 staff member was Trained in CPI on each the following dates 17/12/2014, 05/12/2014, 09/12/2014, 02/12/2014 and 29/01/2015. In the second house 6 staff received Training in Crisis Prevention Intervention on 16/12/2014 and 1 staff member received Training on 26/01/2015.

5. All staff will receive Training in Manual Handling. All staff in the designated centre are scheduled to attend Training on 16/02/2015 and 19/02/2015.

6. All staff will receive Training in the administration of Oxygen. All residents who have been prescribed Oxygen will have a protocol in place for the administration of Oxygen identified in their Care Plan.

7. All staff in the designated centre will receive HACCAP Training. HACCAP Training is in the process of being sourced for the designated centre.

Proposed Timescale:
1. 28/02/2015
2. 28/02/2015
3. 28/02/2015
4. 28/02/2015
5. 28/02/2015
6. 28/02/2015
7. 31/03/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of staff supervision.

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:
1. The Assistant Director of Nursing will visit the service weekly. This visit will be to review reports and to ensure that the Service is safe, appropriate to resident's needs and effectively monitored. A record of weekly visits to the centre will be maintained by the Assistant Director of Nursing.

2. There is a Plan in place to change the shift patterns of the Persons in Charge/ CNM2 in each house to ensure that there is effective and consistent daily staff supervision in the houses.

3. A forum has commenced for weekly Meetings with Clinical Nurse Managers, the Director of Nursing and Assistant Director of Nursing to take place. This forum provides Clinical Governance through addressing Quality Issues in practice, Improving practice and Care for Service Users, supporting and promoting learning for Clinical Managers.

4. The Clinical Nurse Manager will have Monthly house meetings with all staff working in the designated centre with immediate effect.

5. All staff in the designated centre will have a Performance Planning and Personal Development meeting with their Manager.

Proposed Timescale:
1. 31/12/2014
2. 31/04/2015
3. 16/12/2014
4. 16/12/2014
5. 30/04/2015