

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003361
Centre county:	Kerry
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ann Sheehan
Lead inspector:	John Greaney
Support inspector(s):	Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	27
Number of vacancies on the date of inspection:	3

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 1 day(s).

The inspection took place over the following dates and times

From: 26 February 2015 08:30 To: 26 February 2015 19:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the second inspection of the centre. The purpose of this inspection was to follow up on the action plan and provider's response to the previous inspection of 18 and 19 June 2014 to establish if improvements and appropriate action had been undertaken within the timeframes specified by the provider. As part of the inspection process, inspectors met with residents, person in charge and members of staff. Inspectors observed practices and reviewed documentation such as care plans, medical records, personnel files, training records, and policies and procedures.

Most of the residents had been transferred to the centre from a mental health facility and care was provided by registered psychiatric nurses from mental health services under the direction of a consultant psychiatrist. The previous inspection identified that the centre was in the process of transition. No new admissions were being accepted and plans were in place to support residents' transition to the community. Inspectors were informed that in excess of 12 residents were anticipated to have transitioned to the community by March 2015, however, on this inspection it was identified that only one resident had moved to a community setting as the transition

process had stalled due to lack of resources. Inspectors were informed that this was a cause of concern for some residents who were worried that their expectations of moving to the community would not be realised.

Staff working in the centre adequately addressed the physical and medical needs of residents. Staff members from an external disability provider visited the centre each day to develop personal support plans and facilitate training for residents in life skills such as cooking and also took residents to outings in the community. The care provided to residents on a day-to-day basis within the centre was institutional in nature and did not support residents to enhance their skills to prepare them to live as independently as possible in a community setting. For example, residents were unable to access kitchen facilities to prepare a snack or refreshment regardless of their ability to do so and there was no risk assessment to determine that this restriction was appropriate for all residents. Other institutional practices included a bath/shower list posted in each of the bathrooms detailing the days of the week each resident should have a shower/bath.

Other findings of significance during this inspection related to the design and layout of the premises, particularly in relation to the sense of confinement due to the inadequate size of the premises and the absence of adequate and suitable communal space for residents with a potential for behaviour that challenges and the lack of suitable sanitary facilities. The premises was also found to be unclean throughout and in need of repair.

There were not sufficient numbers of staff at all times and the skill mix was not appropriate in relation to the provision of based on a social model rather than a medical model of care. Many staff had not attended appropriate training to support them provide evidence-based care particularly in relation to communicating with residents and in the management of behaviours that challenged. Other required improvements included:

- the management of complaints
- availability of information in an accessible format
- the use of aids/assistive technology in communicating with residents
- personal support plans
- risk management and emergency planning
- fire safety
- staff knowledge of regulations and standards
- personnel records

The action plan at the end of the report includes the immediate action plan issued to the provider and identifies additional improvements required to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Issues identified for improvement on the previous inspection included:

- there was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre, such as through residents meetings or resident/relative surveys
- some bedrooms were locked during the day to prevent damage to their property by other residents
- inspectors were informed that a religious service was available for residents off-site, but based on discussions with staff, residents were not routinely consulted regarding whether or not they would like to attend
- based on the degree of disability of the residents in the centre, inspectors were not satisfied that the advocacy service was sufficiently proactive in supporting residents make a complaint
- there was inadequate evidence that all residents sharing rooms were happy to do so particularly in light of the challenging behaviour of one resident
- based on the degree of disability of the residents in the centre, inspectors were not satisfied that the advocacy service was sufficiently proactive in supporting residents make a complaint
- the complaints notice was on display in the visitors room in one of the units, however, it was not on prominent display throughout the centre and was not in an accessible format
- there were two complaints processes in operation in the centre
- there was no person nominated to oversee the complaints procedure.

A residents' forum had been convened and minutes of meetings were viewed by inspectors. A family forum had also been established and minutes were available identifying issues discussed including plans for residents to move to a community setting and that some residents were unhappy that other residents did not respect their privacy. It was noted at the last inspection that residents' bedrooms were locked to prevent other residents entering their rooms and damaging their property. The provider's response indicated that coded keypads would be fitted to doors to facilitate residents with the capacity to use the keypads to lock their doors. However, these keypads had not been fitted on the day of inspection. During this inspection, inspectors were informed there were plans for thumb locks to be fitted to bedroom doors to allow residents have privacy but would also facilitate staff to access the room from the outside in the event of an emergency, however, these had not been fitted. Inspectors observed a staff member enter residents' bedrooms without knocking, a practice that did not respect the privacy and dignity of residents.

Staff members confirmed to inspectors that while the religious preferences of residents was respected there were no changes since the last inspection in relation to supporting residents attend religious services.

A residents' advocate had been appointed who visited the centre on a number of days each week. The advocate also facilitated activities for residents and residents were familiar with her.

It was identified on the last inspection that a resident with significant communication difficulties shared a bedroom with a resident that presented with significant behaviour that challenged and there was no evidence to determine if the resident was happy with this arrangement. Following the inspection one of the residents was moved to another bedroom, however, residents continued to share bedrooms and it was noted in a sample of residents' personal plans viewed by inspectors that not all residents who shared a bedroom were happy to do so.

Inspectors reviewed the complaints policy that identified the person responsible for dealing with complaints and contained an appeals process. However, it was not clear who was responsible for ensuring that all complaints were appropriately responded to and that adequate records were maintained as specified in the regulations. The complaints process was on display, however, it was not in an accessible format given the nature of the disability of residents living in the centre. Inspectors reviewed the complaints log and while it was possible to determine whether or not the complainant was satisfied with the outcome of some complaints, however, this was not possible for all complaints recorded.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

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

Findings:

Issues identified for improvement from the previous inspection included:

- there was no evidence of the use of assistive technology to support residents with communication difficulties to communicate
- information was not routinely provided in a format accessible by residents based on their communication requirements.

There was no change in the profile of residents living in the centre from the last inspection and therefore some residents continued to have significant communication needs. The centre had recently gained access to the services of a speech and language therapist and the process of assessing residents had just commenced. Therefore, there continued to be a number of residents that required assessment from a communication perspective. There was insufficient evidence of the use of assistive technology/devices to support staff communicate with residents with communication. There was some evidence of improvements in relation to the availability of information in an accessible format, such as contracts of care, however, improvements were still required, for example, the complaints process was not on display in an accessible format and personal support plans were not available in an accessible format.

The policy on communicating with residents remained in draft format and there was minimal evidence of staff training in relation to communicating with residents.

Judgment:

Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

The admissions and discharge policy remained in draft format as found on the last inspection.

Contracts of care had been recently issued to all residents and/or their relatives. On the day of inspection only a small number had been signed and dated.

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):

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

Findings:

Issues identified for improvement from the previous inspection included:

- on the days of inspection residents did not have a comprehensive operational personal support plan in place
- improvements were required in the development of personal plans in relation to the involvement of other members of a multidisciplinary team such as speech and language

therapy and occupational therapy

- evidence-based tools for the assessment of issues such as falls risk and the risk of developing pressure sores were not used.

In accordance with the findings of the last inspection, the centre was in a process of transition from mental health services to disability services. The process of transition included the development of personal support plans by staff from an external disability provider organisation in conjunction with staff employed in the centre. There was also evidence of consultation with residents and their families in the development of the plans, where relevant. Based on a review of personal plans by inspectors there continued to be a number of residents for which personal support plans had not yet been developed. However, even where personal support plans were developed, it was not always evident that they were implemented in practice. For example, the support plan of one resident stated he needed the support of an organisation for people with a hearing impairment however, there was insufficient evidence that this issue had been addressed. Additionally, the support plan of one resident stated that he had a risk assessment completed in relation to his personal safety and access to the community however, a copy of this risk assessment was not available to inspectors on the day of inspection. All residents did not have support plans available in an accessible format.

Access to dietetics and speech and language therapy had recently been obtained and the process of assessment of residents and a process of assessment was underway.

Staff working in the centre adequately addressed the physical and medical needs of residents. Staff members from an external disability provider visited the centre each day to develop personal support plans and facilitate training for residents in life skills such as cooking and also took residents to outings in the community. The care provided to residents on a day-to-day basis within the centre was institutional in nature and did not support residents to enhance their skills to prepare them to live as independently as possible in a community setting. For example, residents were unable to access kitchen facilities to prepare a snack or refreshment regardless of their ability to do so and there was no risk assessment to determine that this restriction was appropriate for all residents. Other institutional practices included a bath/shower list posted in each of the bathrooms detailing the days of the week each resident should have a shower/bath. These practices were not based on personal support plans, which were not implemented by staff working full time in the centre.

A finding on the previous inspection was the absence of evidence-based tools for assessing residents' likelihood of falling or developing pressure sores. Inspectors noted that one resident had a falls risk assessment completed following a fall in which he sustained a significant injury. However, there was no evidence of reassessment even though an excess of six months had elapsed since this assessment.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The centre comprised two separate buildings on large, well maintained grounds on the outskirts of a large town. Each building was subdivided into three smaller self-contained units with bedroom accommodation for five residents in each and also contained a small kitchenette, a sitting room and a dining room that opened out into a small secure garden. Sanitary facilities comprised of one toilet and one assisted shower in each of the six units, however, one of the shower rooms also contained a standard bath. In total, there were 22 single bedrooms and four twin bedrooms. Bedrooms were adequate in size and had adequate wardrobe space in each for residents to store clothing and personal possessions, however many of the bedrooms did not contain a bedside locker.

Overall inspectors were not satisfied that the centre was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. There was only one toilet for use by five residents in each of the units. Staff members spoken with by inspectors acknowledged that this was insufficient and residents frequently had to use the toilet in one of the other units. There were a number of twin bedrooms in the centre and there was not adequate screening provided at all times to protect the privacy and dignity of residents. Some residents that shared a bedroom expressed a preference for a single bedroom but this was not facilitated for all. In addition, some residents stated that they had occasional arguments with their roommate. Communal facilities comprised a sitting room and a small dining room. Given that a number of residents presented with behaviours that challenge, inspectors were not satisfied that there was adequate communal facilities and the confined nature of the premises had the potential to contribute to an escalation of that behaviour.

In concurrence with the findings of the previous inspection, the inspectors acknowledge that maintaining the centre in a good state of repair presented a challenge due to the behaviour of some residents, that occasionally resulted in damage to fixtures and fittings, however, the centre was in need of redecoration due to damaged wardrobes, damaged plasterwork, damaged furniture and chipped paintwork. In addition to this the centre was noticeably unclean and in need of repair. For example:

- some wash hand basins contained a visible coating of dust
- mould was noted on the grouting in showers
- some curtains were stained with a mould like substance

- there were cobwebs on some windows
- there was dust on air vents
- there was a brown stain around the base of some toilet bowls and there was a pool of fluid suggesting that there was a leak in one
- there was an offensive odour in some of the toilets
- some radiators were rusty
- the floor covering was significantly damaged in parts of the building
- toilet brushes were stored on the floor of shower rooms.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Issues identified for improvement from the last inspection and remained outstanding on this inspection, included:

- there was insufficient evidence of feedback to staff for the purpose of learning and prevention of recurrence of accidents and incidents
- the risk management policy did not address the measures in place to mitigate against the unexplained absence of a resident
- the risk management policy did not address the measures in place to mitigate against aggression and violence
- the risk management policy did not address the measures in place to mitigate against self-harm
- there was an emergency plan, however, it only addressed the evacuation of residents in the event of an emergency but did not address the safe placement of residents in the event of a prolonged evacuation or other emergencies such as loss of electricity, loss of heating, loss of water or flooding
- fire extinguishers were located in locked offices making them difficult to access in the event of an emergency.
- training records indicated that not all staff members had received up-to-date training in fire safety
- a small number of fire doors were held open with door wedges, which was not in compliance with good fire safety practices.

There was a safety statement dated January 2015. However, the risk management

policy and emergency plan were in draft format, were not signed or dated and hence were not operational. A finding at the last inspection was the absence of a process of suitable feedback/learning to staff following accidents and incidents to minimise their reoccurrence. This action was not adequately addressed as demonstrated by the fact that a resident had absconded from the centre previously and was returned to the centre by Gardaí, however, a number of staff members spoken with by inspectors were not aware of this incident. Additionally, there was no operational policy available on the management of residents at risk of absconsion.

Inspectors viewed the fire safety register that identified the quarterly servicing of the fire alarm and the annual servicing of fire safety equipment. There were records of daily checks of issues such as ensuring that fire exits were free from obstruction. However, a record of preventive maintenance of emergency lighting was not available. Training records indicated that a significant number of staff members had not attended up-to-date training in fire safety. Records of fire drills indicated that the most recent fire drill took place in March 2014. Not all members of staff spoken with by inspectors had participated in a fire drill in the centre, were knowledgeable of the location of the fire alarm panel or demonstrated an adequate knowledge of what to do in the event of a fire.

Inspectors observed the use of door wedges being used to keep fire doors open which was in contravention of good fire safety practice. A door leading to an emergency exit was locked and the key was only available to staff. This exit would not be accessible by residents or visitors in the event of a fire even though emergency signage directed evacuation via this route. Due to the behaviour of some residents fire extinguishers were secured from access and were only accessible by staff. Staff members informed inspectors that this practice was approved by the fire safety officer, however, there was no risk assessment of this practice.

A small number of residents smoked and there were risk assessment in place to assess the appropriate level of access to cigarettes and lighter/matches. However, the risk assessment was not adequate as it did not adequately identify additional control measures where existing control measures were not adequate. For example, a residents had sustained a burn from smoking but refused to wear a fire retardant apron, however, additional control measures were not identified to mitigate the risk of not wearing the apron; additionally, not all staff members were knowledgeable of the resident's risk assessment.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Issues identified for improvement from the previous inspection and remained outstanding on this inspection included:

- personal care plans did not adequately outline positive behavioural support to alleviate the underlying causes of behaviour that is challenging
- there was evidence that staff were facilitated with training on behavioural support planning but training records indicated poor attendance
- records indicated, and it was confirmed by the provider and person in charge, that staff had not received training on the prevention, detection or response to abuse.

The policy for the protection of residents from abuse remained in draft format and had not been approved for implementation. There were no records of incidents or allegations of abuse.

Based on the observations of inspectors, staff interacted with residents in an appropriate and respectful manner and were knowledgeable of appropriate positive behavioural support for individual residents. Records indicated, and it was confirmed by the provider and person in charge, that staff had not received training on the prevention, detection or response to abuse, which was also a finding of the previous inspection. Personal care plans reviewed by inspectors contained positive behavioural support to alleviate the underlying causes of behaviour that was challenging for some however, not all residents.

As stated previously in this report, there were a number of residents that displayed behaviour that was challenging and as identified during the previous inspection, there was evidence that staff were facilitated with training on behavioural support however, training records indicated poor attendance. Based on a sample of records viewed by inspectors there were appropriate systems in place for the management of residents' finances.

Judgment:

Non Compliant - Major

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

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

Findings:

Issues identified for improvement from the previous inspection and remained outstanding on this inspection included:

- there was insufficient evidence to demonstrate that residents had been facilitated with education and training to support them achieve their potential.

Many of the residents in the centre had lived in institutional settings for a significant portion of their lives and many of the residents resided in mental health facilities from an early age. A process of transition had commenced in preparation for residents moving to community settings. The transition process was predominantly managed by an external disability provider. However, as already stated under outcome 5 of this report, the process of preparing residents for transition to the community did not appear to be incorporated into residents' daily routine. Inspectors were not satisfied that there was a robust transitional process to support residents to maximise their independence.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Issues identified for improvement from the previous inspection included:

- there was insufficient evidence of access to other allied health/specialist services such as speech and language therapy and dietetics or of a programme of referral to dental services as part of a programme of preventive care.

This action had been satisfactorily addressed. Since the previous inspection dietetics and speech and language therapy services were now available in the centre and a process of assessment had commenced. A dentist was scheduled to visit the centre in the weeks following this inspection.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

Issues identified for improvement from the previous inspection included:

- medications stored inappropriately in a basket in one of the kitchens
- the fridge thermometer was not functioning in one of the medication fridges and fridge temperatures were not always recorded daily
- some medications in a "stock" cupboard were out-of-date
- there was no system for returning unused or out-of-date medications to the pharmacy
- there was no evidence of ongoing medication management training by all nursing staff
- there was an inadequate system for reviewing medication management practices as none of the above non-compliances were captured in a recent medication management audit.

Most of the above actions had been satisfactorily addressed. The medication management policy was in draft format and was not signed or dated. Medications were stored appropriately in treatment rooms and were secure from unauthorised access. There were no stock medications, and based on a sample of medications viewed by inspectors, all medications were in date. There was an appropriate system in place for the return of unused/out-of-date medicines to the pharmacy. There was evidence of audits of medication management practices carried out by a pharmacist and no issues were identified for improvement.

However, there continued to be inadequate evidence of ongoing training in medication management by staff. A review of a sample of prescription and administration records indicated that all appropriate identify information was recorded, however, the prescription and administration record were not centre specific and contained the identity of a psychiatric facility.

Judgment:
Non Compliant - Minor

Outcome 13: Statement of Purpose

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

Theme:
Leadership, Governance and Management

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

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

Findings:

There was a written statement of purpose that described the service to be provided and contained all the information required by the regulations.

Judgment:
Compliant

Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

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

Findings:

Issues identified for improvement from the previous inspection and remained outstanding on this inspection included:

- inspectors formed the view that, based on the profile of residents in the centre and the absence of staff with suitable training in intellectual disability, that the care of residents could be enhanced by the addition of social care staff to support nursing staff in the provision of care
- based on a review of a sample of personnel records many of the items listed in Schedule 2 of the Regulations were not in place for staff
- while staff members were equipped to provide psychiatric and other nursing care to residents, there was minimal evidence of attendance by staff at training to support them develop the skills required to support residents with an intellectual disability.

As stated under outcome 6, the centre comprised of two separate buildings and each building was subdivided into three smaller self-contained units with accommodation for five residents in each unit. On the day of the inspection there were 13 residents in one building and staffing consisted of one clinical nurse manager (CNM), four staff nurses and two housekeeping staff. One of the staff nurses was assigned as a "special" (nurse assigned to provide on-to-one care for a particular resident). The two housekeeping staff were responsible for cleaning the three units and also for kitchen duties, including serving meals, which were prepared externally and delivered to the centre in heated containers. In the second building there were 14 residents and staffing consisted of one clinical nurse manager (CNM), three staff nurses and two housekeeping staff. One of the staff nurses in this building was also assigned as a "special". At 18:23hrs each day nursing staff was reduced to three staff nurses in each building, including the "special" nurses.

There were additional staff present in the centre for various periods of time each week to support residents transition to the community including a psychologist, a community living facilitator and an intellectual disability nurse. There were also staff from external disability organisations that took residents on outings to the community and some residents had personal assistants for a number of hours each week.

All of the nursing staff were registered psychiatric nurses and none had a qualification in intellectual disability nursing. However, training records viewed by inspectors indicated that a number of staff did not have up-to-date training in fire safety, manual handling and records indicated that there was minimal attendance at adult protection and prevention of abuse. In addition, not all staff members had attended training in positive behavioural support or the management of aggression and violence. A number of residents living in the centre present with behaviour that challenges that at times manifested as physical outbursts.

Overall, based on discussions with staff members, observations of inspectors and the needs of residents living in the centre, there were insufficient staff at all times to meet the needs of residents and in particular to support residents participate in activities. On the morning of the inspection, inspectors observed residents in one unit sitting on chairs or lying on couches without any stimulation other than a television playing a show that did not appear to capture the interest of any of the residents. The evidence available to inspectors from written records, discussion with staff and observation of residents,

suggested that the potential of residents was not maximised. Based on the findings of this inspection in relation to the cleanliness of the centre the provider nominee and person in charge were requested to review the cleaning rota to ensure that the centre was appropriately clean.

Inspectors reviewed a sample of personnel records. Many of the items listed in Schedule 2 of the Regulations were not in place for staff, including:

- up-to-date photographic identification
- vetting disclosure
- a full employment history
- current registration status for nursing staff
- two written references including a reference from a person's most recent employer (if any).

This was also a finding at the last inspection however, no significant improvement has been made in the interim.

Based on discussions with staff, not all were familiar with the Health Act 2007, regulations or standards governing the provision of care to residents with an intellectual disability.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

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

Findings:

Most of the policies listed in Schedule 5 of the regulations were in draft format. Since the previous inspection in June 2014, only three policies had been approved for implementation.

The inspectors reviewed the directory of residents and were satisfied that it contained all the items listed in the regulations.

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003361
Date of Inspection:	26 February 2015
Date of response:	15 May 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:

Inspectors were not satisfied that the dignity and privacy of residents was respected at all times, for example:

- inspectors observed a staff member enter residents' bedrooms without knocking
- residents did not have the facility to lock their bedroom doors
- some residents shared a bedroom and it was not always evident that this was by choice.

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:

- Staff have been reminded about respecting people's privacy by ensuring they knock when entering individuals bedrooms. This practice will be monitored to ensure compliance by all staff at all times.
- Thumb locks have been fitted to bedroom doors to give residents the opportunity for privacy in their own bedrooms.
- Where residents are sharing bedrooms, a discussion has been had with all residents sharing rooms to ascertain their wishes. These wishes are recorded and where change has been recognised, as soon as it is possible, we will work to facilitate their wishes. Screens are now in place for rooms that are being shared.

Proposed Timescale: 15/05/2015**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staff members confirmed to inspectors that while the religious preferences of residents was respected there were no changes since the last inspection in relation to supporting residents attend religious services.

Action Required:

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

- Information on individual rights including voting are in readable format in the Residents Forum information file and will form part of monthly agenda.
- Mary Carroll, National Advocate will be coming to the unit to talk with the residents about their rights within the next week with a number of sessions to be put in place.
- All residents have been offered the opportunity to attend mass at 11am every Sunday at the local Church. Each resident will be supported to attend this if required.
- Arrangements are also in place for any residents who wish to attend mass in the O'Connor Unit on Thursday afternoons.
- Attempts are on-going to arrange for a local priest to Mass on a regular basis.
- Through the PCP process, if any specific preferences for attending Mass are identified, supports will be put in place to support the resident to attend religious ceremonies.
- Mass times are displayed in the centre.

Proposed Timescale: 15/05/2015

Theme: Individualised Supports and Care

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

It was not clear from the complaints policy who was responsible for ensuring that all complaints were appropriately responded to and that adequate records were maintained.

Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

- The process for managing complaints has been revised as follows:

A new form has been put in place on each unit which captures complaints only.

The CMN11/A CMN11 will at all times endeavour to deal with complaints as they are received.

If the CMN11/ACMN11 cannot resolve complaint, it is forwarded onto the Complaints Officer, Christine Carroll. The CMN11/ ACMN11 will support the person to formalise the complaint to the Complaints Officer. Information will also be provided on Your Service Your Say complaints process.

The Complaints Officer will log all complaints and work with the PIC to ensure required responses are provided in time to ensure the complaint is dealt with in a timely manner. Details of all complaints will be brought by the Complaints Officer to Cluain Fhionnain Management Governance Group on a monthly basis.

- The Complaints PPPG will be updated to reflect these changes.

Proposed Timescale: 15/06/2015

Theme: Individualised Supports and Care

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

The complaints process was on display, however, it was not in an accessible format given the nature of the disability of residents living in the centre

Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

- An Easy to Read format is available in accessible format. This has been circulated in both houses and at the Family Forum meeting in April 2015.
- It is displayed in a wall mounted folder for all residents to access in both bungalows.

Proposed Timescale: 22/05/2015

Theme: Individualised Supports and Care

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

While it was possible to determine whether or not the complainant was satisfied with the outcome of some complaints, this was not possible for all complaints recorded.

Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

- As above a complaints folder already exists on both units. The form has been modified to include only complaints.
- The complaints are then forwarded to the Complaints officer who will log the complaints onto the Complaints log folder for the service.
- All complaint including those resolved at unit level are forwarded to the Complaints Officer
- The Complaints Officer will report to the Management Governance Group on a monthly basis, the details of all complaints.
- The Complaints PPPG will be revised to reflect these changes.

Proposed Timescale: 30/06/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Information was not routinely provided in a format accessible by residents based on their communication requirements.

Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

- There is a folder with all Easy Read documents which will be used as appropriate during the Residents monthly forum meetings
- Through PCP process, communication preferences will be identified and documented. The appropriate tools to support the identified communication requirements will be provided.

- All staff will be made aware of any specific communication tools.
- Where additional communication supports or communication devices are required, this will be accommodated.

Proposed Timescale: 15/05/2015

Theme: Individualised Supports and Care

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

There was insufficient evidence of the use of assistive technology/devices to support staff communicate with residents with communication.

Action Required:

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

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

- Through PCP process, communication preferences will be identified and documented. Where assistive technology and aids and appliances are required, following appropriate assessments, they will be provided. A budget has been made available for such items.

Proposed Timescale: 15/05/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Contracts of care had been recently issued to all residents and/or their relatives. On the day of inspection only a small number had been signed and dated.

Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

- The Contract was shown to all residents which are in an Easy to Read format but due to capacity issues, they were not requested to sign same. This is documented in residents files.
- The Contract of Care was also sent out to all family members with a letter outlining the purpose of it. Family members were not requested to sign same as there is no legal base for that. A copy of the Contract of Care and the letter sent to families is contained in each residents file.

- For existing clients a Contract of Care has been placed in each file with the letter which was sent out to all relatives.
- For any new emergencies: The Contract of Care will be discussed with the individual and the family prior to admission and where appropriate, the individual will be requested to sign same.

Proposed Timescale: 15/05/2015

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:

There continued to be a small number of residents for which personal support plans had not yet been developed

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

- The development of Support Plans and PCP's has been done on a phased basis as it was agreed by the Management Governance Group that they should be done in a meaningful way and very thoroughly as they will form the basis of individual transition plans as people prepare to move out to community accommodation.
- There are now 25 plans in progress with a further 3 to commence. All plans will be in progress by the end of June 2015. Work will be on-going on these plans as people are preparing for transiting to the community.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Personal plans were not available in an accessible format.

Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

- Planning for PCP's will be done ensuring that all documentation is in an accessible format.

- As new PCP's are developed, where practical and appropriate, plans will be in an accessible format.
 - As people transition out, PCP's will continue in accessible format and form part of the residents property where safekeeping of same for each individual will be considered.
- In Progress

Proposed Timescale: 15/05/2015

Theme: Effective Services

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

Where personal support plans were developed, it was not always evident that they were implemented in practice.

Action Required:

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

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

- An activity sheet has been put in place to cover all day centre and 24hr residential activities.
- These sheets will be updated daily by the Transition team and Staff from the designated centre.
- Individual PCPs will be reviewed jointly every week by Transition team staff and residential staff.

Proposed Timescale: 15/05/2015

Theme: Effective Services

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

Inspectors were not satisfied that there evidence-based tools for the assessment of residents were appropriately utilised.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

- Support Plans and PCP's are being developed through a process of in depth discussion with individual, family and staff using a comprehensive, recognised planning tools.
- Where further assessments are indicated such as physiotherapy, Occupational therapy, dietetics, professionals utilise their recognised assessment tools which then informs the residents support plans.

- Recognised risk assessment tools are now being put in place which includes: FALLS's Assessments and an adapted comprehensive risk assessment process.

Proposed Timescale: 15/05/2015

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 were not satisfied that the centre was designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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:

- There is a closure plan in place for designated centre over the next 12 months so it is not anticipated that any remedial work will be done beyond ensuring the buildings meet Health and Safety standards.
- The first group of residents is scheduled to move out by the end of June with other moves planned for the remainder of the year. As more space becomes available, every effort will be made to ensure it is used for the comfort of the remaining residents.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

The centre was not in a good state of repair. For example, there were:

- damaged wardrobes
- damaged plasterwork
- damaged furniture
- chipped paintwork
- rusty radiators
- there was a brown stain around the base of some toilet bowls and there was a pool of fluid suggesting that there was a leak in one
- floor covering was damaged

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:

- As it is planned that the designated centre is closing down within the next 12 months, the Management Governance Group are committing to ensuring all essential maintenance work is completed and the centre is kept in a reasonable state of repair. The Management Governance Group are prioritising all available funding to assist with preparing people to transition out into the community as part of the Closure Plan for the designated centre.
- There is a system in place for CMN11's on each unit to request maintenance work to be carried out as required within the units.
- CMN11's have been advised to ensure maintenance requests are submitted and funding will be approved as per the criteria agreed by the Management Governance Group.
- An Annual Review has been commissioned for the designated centre for June 19th 2015. The outcome of this will be submitted to the Management Governance Group who will review same and consider any additional work that may be required to ensure a safe environment for residents and staff.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

The centre was not suitably clean. For example:

- some wash hand basins contained a visible coating of dust
- mould was noted on the grouting in showers
- some curtains were stained with a mould like substance
- there were cobwebs on some windows
- there was dust on air vents
- there was an offensive odour in some of the toilets
- toilet brushes were stored on the floor of shower rooms

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:

- A schedule for cleaning has been developed and is being implemented to ensure the premises are clean.
- The Housekeeping supervisor will assess and monitor the effectiveness of the cleaning schedule on a monthly basis.

Proposed Timescale: 15/05/2015

Theme: Effective Services

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

the following respect:

The centre was not suitable for the needs of the residents. For example:

- there was inadequate communal space for the number and needs of residents living in the centre
- there was inadequate storage for equipment
- there were inadequate sanitary 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:

- There is a closure plan in place for the designated centre over the next 12 months so it is not anticipated that any remedial work will be done beyond ensuring the buildings meet Health and Safety standards.
- The first group of residents is scheduled to move out by the end of June with other moves planned for the remainder of the year. As more space becomes available, every effort will be made to ensure it is used for the comfort of the remaining residents.

Proposed Timescale: 30/06/2016

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:

Inspectors were not satisfied that there were adequate systems in place for the management of risk. For example:

- there was an inadequate process for feedback to staff following accidents/incidents to prevent reoccurrence
- the risk management policy and emergency plan were in draft format, were not signed or dated and hence were not operational
- the risk assessment and management of residents that smoked was inadequate

Action Required:

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

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

- The Risk Management PPPG has been signed off and is being implemented. However, in light of more changes that have been put in place to ensure we are managing risks appropriately, the PPPG is being revised.
- The emergency plan will be reviewed and updated.
- A baseline risk assessment has been carried out on all residents.
- A comprehensive risk assessment is being undertaken for each resident as indicated by the baseline risk assessment.

- Risk assessments conducted by the transition team are being amalgamated to ensure that there is one risk assessment plan for each individual.
- The individual with the smoking risk assessment is being reviewed and updated to reflect additional control measures that can be put in place.
- Risk register for the designated centre will be reviewed and updated by the Risk Manager and the PIC through the Multi-Disciplinary Transition Team on a monthly basis.
- The Risk Register will be reviewed by the Management Governance Group on a monthly basis. Risk Management will also be a standing agenda item on all the Management Governance Meetings.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

No all staff had received up-to-date training in fire safety.

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:

- 2 additional Fire Safety Training programmes has been rolled out with a plan for regular Fire Safety Training programmes to be held. Fire Safety Training will form a part of on-going training plans for staff in the designated centre.

Proposed Timescale: 30/06/2015

Theme: Effective Services

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

Fire drills were not held regularly.

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:

- 2 fire drills have taken place over the last 2 months.
- A process is being set up with CMN11's to carry out monthly fire drills following further training with the Fire Officer.

- Fire evacuation Plans will be regularly discussed at the Residents Forum meetings.
- In Progress

Proposed Timescale: 15/05/2015

Theme: Effective Services

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

Records of preventive maintenance of emergency lighting were not available.

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:

- All exit areas are free of any clutter in the event of an emergency evacuation.
- There is emergency lighting in all areas
- All maintenance records will be maintained on site within the designated centre including maintenance of Emergency Lighting.

Proposed Timescale: 15/05/2015

Theme: Effective Services

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

An emergency exit was inaccessible due to a locked outer door.

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:

- A fire evacuation plan is in place which ensures that all fire exits are accessible.

Proposed Timescale: 15/05/2015

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:

Not all staff had received training in managing 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:

- A training plan is in place to provide all staff with training in PMAV and Behaviour Support Planning. All staff are being encouraged to do the training and when possible, they are being released from the centre. Due to the complexity of needs in the service, all training has to be done on a phased basis as staff from the units cannot be easily replaced.

On going

Proposed Timescale: 15/05/2015

Theme: Safe Services

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

Staff had not received training in adult protection.

Action Required:

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

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

- 2 training sessions have been provided in the last 6 weeks with further training scheduled for the end of this month.
- Training lists are being maintained which will be reviewed on a monthly basis by the Management Governance Group.

Proposed Timescale: 15/05/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

The process of preparing residents for transition to the community did not appear to be incorporated into residents' daily routine.

Action Required:

Under Regulation 13 (4) (b) you are required to: Ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

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

- A daily activities sheet has been put in place which will be updated by the Transition team and the Residential staff. This will allow for the sharing of training programmes between both staff.
- Transition team and residential staff will jointly update the individuals PCP on a weekly basis with actions agreed jointly.
- The residential staff will work on the training plans developed by the transition team.

In Progress

Proposed Timescale: 15/05/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

Improvements were required in relation to staffing, as:

- there were insufficient staff at all times to meet the needs of residents and in particular to support residents participate in activities.
- based on the findings of this inspection in relation to the cleanliness of the centre the provider nominee and person in charge were requested to review the cleaning rota to ensure that the centre was appropriately clean.

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:

- Due to the historical nature of this service and the agreed closure plan for the designated centre, it is not anticipated that skill mix will be changed.
- However, all staff are being offered and provided with training programmes specifically designed to meet the needs of people with intellectual disabilities.

- To support the development of Support plans and PCPs, a Person Centred Planning facilitator has been engaged to complete same and work with staff to develop their understanding of processes.
- A transition team of suitably experienced staff with Intellectual Disability experience has been contracted to develop transition plans and plan for future services in the community where the assessed needs of the individuals will dictate the skill mix required in the various houses.
- Through PCP's where additional one to one supports are required to support people to engage in social activities, this will be provided

Proposed Timescale:

Theme: Responsive Workforce

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

Many of the items listed in Schedule 2 of the Regulations were not in place for staff, including:

- up-to-date photographic identification
- vetting disclosure
- a full employment history
- current registration status for nursing staff
- two written references including a reference from a person's most recent employer (if any).

Action Required:

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

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

- All staff have been written to again requesting the outstanding documentation
- In the event of continued non-compliance by staff in the provision of this information, one to one meetings will be held with staff members by their line managers stressing the importance of submitting this information

Proposed Timescale: 30/06/2015

Theme: Responsive Workforce

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

The level of attendance at training by staff did not support them provide care for the profile of residents living in the centre. For example. not all staff had attended training on:

- adult protection and the prevention of abuse
- positive behaviour support

- communication
- the management of aggression and violence
- manual handling
- medication management
- fire safety.

Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

- A training plan is being rolled out to ensure that mandatory training is being offered on a regular basis.
- It continues to be a challenge to ensure all staff receive training as they are working over a 24 hour roster and it can be difficult to replace staff for training due to the complexity of needs of the client group.
- Comprehensive training records are being maintained which will be reviewed by the Management Governance Group as we work towards ensuring all staff receive the appropriate training.

On going

Proposed Timescale: 15/05/2015

Theme: Responsive Workforce

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

Not all staff were familiar with the Health Act 2007, regulations or standards governing the provision of care to residents with an intellectual disability.

Action Required:

Under Regulation 16 (1) (c) you are required to: Ensure staff are informed of the Act and any regulations and standards made under it.

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

Copies of the Act are available on both units and CMN11's have been instructed to ensure they are included in the Policy/Standards weekly review meeting with all staff.

Proposed Timescale: 15/05/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Only three of the policies listed in Schedule 5 of the regulations were approved for implementation.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

- All the mandatory Policies and Procedures have now been signed off and are in place.
- A plan is in place whereby the Practice Development Coordinator carries out an information session with staff on each policy. This is scheduled weekly.
- The CMN11's hold weekly meetings with staff to review a policy every week.
- A policy and procedure group was in place to finalise the PPPG's. this group will remain in place to assist with any revisions of PPPG's as they are operationalized.

Proposed Timescale: 15/05/2015