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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003944
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Breda Noonan
Lead inspector:	Julie Hennessy
Support inspector(s):	Kieran Murphy
Type of inspection	Unannounced
Number of residents on the date of inspection:	31
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 inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
27 August 2015 08:30	27 August 2015 18:00

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 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the fifth inspection of this designated centre. This inspection was in response to notices of proposal to refuse and cancel registration of the centre that were issued by the Health Information and Quality Authority ('the Authority') to the Daughters of Charity in response to an application by the provider to register the centre. This inspection followed up on non-compliances from the previous inspection and also considered a submission by the provider in relation to the notices of proposal to refuse and cancel registration of the centre.

Group A comprises four interconnecting dormer bungalows (‘units’). The centre can accommodate 31 residents and is a congregated setting.

There was evidence of some improvement since the previous inspection. For example, advocacy arrangements and the management of complaints had been reviewed and the new arrangements now met the requirements of the Regulations. In addition, the provider nominee had completed an unannounced visit and audit of the centre and other audits had also been completed.

A new person in charge commenced in the centre three weeks prior to this inspection. The person in charge was suitably qualified and experienced to meet the requirements of the role of person in charge. The person in charge demonstrated an understanding of key priorities that needed to be addressed, such as care planning and reviewing MDT recommendations. Although the person in charge was full-time in the centre, she was also acting as the house manager for two of the four units while that house manager is on leave. Due to the short time-frame that the person in charge was in the role, inspectors were not in a position to determine the effectiveness or otherwise of the new arrangements. However, it was not demonstrated that the person in charge had the required supports necessary to enable her to meet the requirements of her role.

Inspectors found a continued high level of non-compliance against the Regulations at this inspection. Four outcomes that were at the level of major non-compliance at the previous inspection remained at the level of major non-compliance at this inspection.

A major non-compliance was identified at the previous inspection in relation to Outcome 5: 'social care needs' and this remains at the level of major non-compliance. The provider had not satisfactorily ensured that the designated centre met the assessed needs of all residents. While the provider demonstrated that steps had been taken to progress this issue, the situation has yet to be fully resolved.

A major non-compliance was identified at the previous inspection in relation to Outcome 6: 'safe and suitable premises' as the provider had not satisfactorily ensured that the design and layout of the centre was suitable for its' stated purpose. While the provider had submitted a costed plan to the Authority to upgrade and improve the premises, this plan was not funded. This outcome remains at the level of major non-compliance.

A major non-compliance was identified at the previous inspection in relation to Outcome 8: 'safeguarding and safety' and this remains at the level of major non-compliance. It was again found on this inspection that the management of restrictive practices required significant improvement. An investigation into a notification submitted to the Authority on 16 June 2015 concerning an allegation of abuse against a member of staff was still outstanding as of 9 November 2015.

A major non-compliance was identified at the previous inspection in relation to Outcome 14: 'governance and management' and this remains at the level of major non-compliance. While the provider had taken a number of steps in line with their previously submitted action plan to address the areas of concern identified in the previous inspections, the management systems in place required further review in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The Authority did not agree this action plan in full with the provider despite affording the provider the opportunity to submit a satisfactory response. The provider's response to Regulations 05 (3), 17 (1) (a), 17(7) and 28 (1) under Outcomes 5, 6 and 7 respectively were not accepted as they did not satisfactorily address the failings identified.

Findings are detailed in the body of this report and should be read in conjunction with the actions outlined in the action plan at the end of the report.

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

Findings:
The actions from the previous inspection had been satisfactorily addressed. However, at this inspection, practices were observed that had the potential to compromise residents' privacy and dignity.

At the previous inspection, it was found that internal advocacy arrangements were inadequate and it was not demonstrated how the advocacy committee was representative of residents.

At this inspection, it was found that a new advocacy committee had been set up and commenced. An inspector viewed minutes of an advocacy meeting and relevant topics were discussed in an appropriate manner, including in relation to residents' rights. Staff had received advocacy training since the previous inspection.

At the previous inspection, it was found that the logging of complaints did not always demonstrate that complainants were informed promptly of the outcome of their complaints and details of the appeals process. As a result, practices were inconsistent.

At this inspection, it was found that the management of complaints met the requirements of the Regulations. A new complaints form had been introduced, staff had received an information session in relation to supporting better practices in the management of complaints and complaints were being logged in accordance with regulatory requirements.

Allegations had been made in December 2014 with respect to not respecting the privacy and dignity of residents when assisting with intimate care. At this inspection, inspectors

walked through three of the four bungalows between 08:30 and 09:00 and observed open bedroom doors in all of those three bungalows. This was made possible in two bungalows by a full-length side-panel that ran alongside the main bedroom door. In the third bungalow, a bedroom door was wedged open by a rug and a resident could be observed in bed in their nightclothes. Inspectors found that this practice compromised the privacy and dignity of residents.

Other practices were observed to be respectful. Bathroom doors were kept closed and staff members were observed knocking on closed doors before entering.

While allegations made in December 2014 related to the use of inappropriate language that may have constituted the verbal abuse of residents, on this inspection, staff members were heard to converse with residents in an appropriate manner.

Judgment:
Non Compliant - Moderate

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:
There were four actions arising from the previous inspection relevant to social care needs. While improvements were demonstrated, one action had been completed in full, two were partially completed and one had not been satisfactorily addressed.

At the previous inspection, it had been identified that where a resident had been in hospital, an up-to-date assessment of the resident's health needs had not always been completed following their return to the centre. In addition, it had been found that the resident's healthcare plan had not been updated to reflect any new treatment issues. Similar findings were made on this inspection.

At the previous inspection, it was found that the designated centre was not suitable for the purposes of meeting the assessed needs of each resident. The finding in relation to

the inappropriate placement remained unchanged. This continued to have a significant impact on a resident in terms of meeting their social, emotional, developmental and safety needs. While the provider nominee demonstrated that steps were being taken to progress this issue, the finding remains at the level of major non-compliance due to the impact on the resident, the length of time that this issue had been on-going (in terms of years) and that a concrete plan is not yet in place.

At the previous inspection, it was found that improvement was required in relation to the setting of residents' goals. At this inspection it was found that improvement had been made for recently updated plans. For example, a recently updated personal plan now outlined the necessary supports to achieve such goals. The person responsible to support residents to achieve their goals and the required timeframe was specified. However, further improvement was required. Some goals were not goals, but related to meeting residents' health needs (e.g. required health referrals and reviews). The tracking of goals required improvement as not all the required monthly records had been completed. The outcome of the goal and how it contributed to the residents' quality of life was not specified.

At the previous inspection, it was found that personal plan reviews were not multidisciplinary, as required by the Regulations. At this inspection, it was demonstrated that while steps had been taken at organisational level to address this failing, it has not yet been addressed. In addition, a previously accepted timeframe of 30.8.2015 to address this issue has not been met.

At the previous inspection, it had not been demonstrated that each resident's personal or skills development needs were being met. At this inspection, it was demonstrated that progress had been made in relation to this area. Most residents had a day service. Where residents did not have a day service, steps were being taken to source a suitable service. For some residents who were unable to attend a day service for valid reasons, 'activation' was provided from the centre. A timetable was now in place for those residents and staff were recording how residents spent their day so that this could be reviewed on an on-going basis. For example, the daily routine of one resident who previously went to bed at 3:30 in the afternoon had been reviewed and revised and this no longer occurred. Opportunities to explore new interests and outings off-campus were also being tried and set as goals for the following year, for example, to visit Botanic gardens, to attend a show or to avail of a spa treatment. The development of fundamental skills formed part of goals, such as bringing toiletries to the bathroom independently. However, further progress in relation to meaningful and varied activities for all residents was required. For example for one resident who did not have a day service, activity records indicated that s/he had been brought out for four walks in the month of August.

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

Findings:
The centre forms part of a congregated setting. There were four units (dormer bungalows) in the centre which were all of a similar size and layout. The ground floor of each unit comprised a kitchen, an open living room/dining space, one very small 'quiet room', eight bedrooms, one shower room, one bathroom (with accessible bath), a toilet, a staff/visitor toilet and a storage room. The first floor contained the laundry facilities, a staff toilet and staff bedroom or office.

At previous inspections, it was found that the design and layout of the centre was not suitable for its' stated purpose and did not meet residents' individual or collective needs in an acceptable way. The poor design and layout of the premises impacted on an individual resident's need for space and did not meet other individual resident's mobility or privacy needs. Due to the confined space in the premises, parts of the premises were in a poor state of repair. All units in the centre had limited storage space.

The provider had acknowledged in a submission to the Authority that the residential units at Group A and were not appropriate to cater for the residents' needs. The provider outlined that two vacant properties had been bought and were being renovated. It was proposed to move four residents into these properties once they were ready to occupy and to reduce the number of residents in each bungalow from eight to six by the end of 2016. In the meantime, the provider outlined that a submission had been made to the Health Service Executive (HSE) regarding the upgrading of the current premises.

While some upgrading works had taken place, particularly in the bathroom areas, it was again found on this inspection that the poor design and layout of the premises continued to have an impact on residents need for space and did not meet residents' mobility or privacy needs or need for personal space. Inspectors observed breakfast in one of the four units. The living/dining room was cramped when residents were at the dining table. The bedroom sizes presented challenges in terms ensuring the safe moving and handling of residents by staff in such confined spaces. Inspectors observed one resident hitting out at another resident in a wheelchair who was in his/her way and a staff member said that space had an impact on individual resident's behaviours that may challenge. As on the previous inspection there was limited natural light in most of the bedrooms due to the design and layout of the units. The walls and doors throughout

each unit were still visibly marked and damaged.

Suitable storage areas for equipment were again not available. Some wheelchairs and chairs assessed for residents by an occupational therapist were stored in the courtyard area outside each unit. In addition, some other chairs stored in the courtyard area were not in use with the possibility that items for maintenance could be used in error. Inspectors saw a dining chair in one main living room with a 'post-it note' on it that it was not in use. Again, there was the possibility of this chair being used in error.

In one unit due to space constraints resident chairs and portable commodes were being stored in the same equipment room with the potential infection control hazards associated with this practice. In another unit the hand gel dispenser for people to clean their hands was coming off the wall, with a 'post-it' note for it to be fixed.

At the last inspection it had been found that some equipment used by residents was unclean, particularly residents' own personal chairs. On this inspection the chairs were clean and were part of a cleaning schedule. In relation to maintenance of residents' chairs and equipment generally this was coordinated via the administration centre of St. Anne's. However, the handles of some portable commode equipment were observed to be in need of replacement.

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:
At the previous inspection, improvements were required to the fire safety management systems, fire safety training, manual handling practices, the risk assessment policy and infection control procedures. The actions relating to fire safety training, the risk assessment policy and infection control procedures had been satisfactorily addressed. Actions were outstanding in relation to the fire safety management systems and manual handling practices.

While the provider had outlined in a submission to the Authority that additional resources had been provided at a management level to address issues in relation to safety of care, a risk assessment of all four houses in the designated centre was to have been completed by 3 July 2015 by a competent person in the area of fire safety. A

costed funded plan to address any required improvement works was not submitted to the Authority within the previously agreed timeframe.

Fire doors were installed throughout the building, including kitchen, bedroom, stairwell, living room and bathroom and store doors. However, inspectors observed that fire doors were visibly damaged. In addition, inspectors observed that there were side panels in many residents' bedrooms that could be left open meaning smoke and fire could easily spread to bedrooms. Finally, the main gates leading into the campus were locked via an automated system at night-time and weekends. A system was required to ensure that this would not impede access of the fire brigade in the event of a fire.

Other improvements to aspects of fire safety management were again identified on this inspection. For example, one resident refused to evacuate the premises during fire drills or would only evacuate by passing the kitchen area to exit via the dining/living area (locations where a fire would be most likely to start). The individual fire risk assessment for that resident had identified that a referral was made to the multi-disciplinary team for restrictive practices to discuss moving the resident safely. When inspectors requested a copy of this referral to the restrictive practices committee it was not available. Inspectors observed that there were monthly fire evacuation drills being undertaken involving the residents and the records of these drills indicated that it had taken 8 minutes to evacuate the premises in August 2015, 7 minutes in June 2015 and 10 minutes in May 2015.

At the previous inspection, it was found that manual handling techniques were being used that were outdated and unsafe and carried a risk of injury to residents.

At this inspection, inspectors again observed manual handling techniques being used that were outdated and unsafe and carried a risk of injury to residents. An inspector reviewed manual handing risk assessments and found that while one provided adequate guidance for staff to assist residents safely, other manual handling risk assessments did not. In addition, manual handing charts were not in use, as is the case in other parts of the Daughters of Charity service (these charts are used as a visual aid to inform staff how to assist a resident safely for any given task that requires manual handling).

Since the previous inspection there was now a centre procedure on risk management. This local procedure included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. It also included how hazards were identified and the method by which incidents were reviewed.

Since the previous inspection, training records indicated that all staff had received training in fire safety. In addition, all bathrooms now had facilities for drying hands.

Judgment:
Non Compliant - Moderate

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:
There were two actions arising from the previous inspection relevant to safeguarding of residents. While progress had been made to address failings identified in the previous inspections, the provider had not satisfactorily implemented either of the actions that had been proposed and accepted by the Authority in their action plan. However, two failings were found to be at the level of major non-compliance. While allegations of abuse at the centre were investigated, the provider failed to demonstrate that all necessary safeguards had been put in place. Adequate safeguards have not been put in place in response to allegations of forced administration of medication.

At the previous inspection, it was found that staff did not accept the possibility that abuse could occur in the centre. In order to address these issues the provider had outlined in a submission to the Authority that contact has been made with an external facilitator in an effort to address the 'cultural' issues in the centre relevant to safeguarding and safety. The provider also outlined that appropriate measures would be put in place to address these issues. The provider nominee and A/CEO confirmed at feedback that no details or indications of progress regarding these measures were available.

Following the previous inspection, the action plan submitted outlined that the CNM3 would attend all unit meetings and that such meetings would address safeguarding issues and the importance of staff recognising that abuse could occur in the centre. At this inspection, it was found that while the CNM3 visited the centre on a weekly basis, she had not attended the three unit meetings that had been held since the new person in charge commenced in the centre. The person in charge confirmed that safeguarding issues had not been discussed at the three most recent unit meetings. When asked, the person in charge said that it had not been explained to her that this was part of the action plan response to address concerns relating to safeguarding. Minutes of a 1:1 supervision meeting between the CNM3 and person in charge did not record that safeguarding issues had been discussed. As a result, the proposed action to address the failing in the previous report has not been satisfactorily implemented.

Allegations had been made in December 2014 with respect to the forced administration

of medication to a resident. At a previous inspection, it was found that that the resident's chin and hands were restrained in the course of the administration of medication inserted in food. The use of such restraints (including cupping the resident's chin) was outlined in an approved protocol that related to feeding and the administration of medication and had also been considered by the multi-disciplinary team. At this inspection, it was found that a new protocol had been developed following the allegations and provided guidance for staff in relation to the administration of medication in the least restrictive manner. The nurse on duty explained that the revised protocol was being implemented and was working well. However, an inspector found that the multi-disciplinary restrictive practice document in the resident's file was dated 29.4.2014 and had not been updated since the protocol had been revised. As a result, the restrictive practices document in place still referenced a practice that was no longer approved i.e. cupping the resident's chin. Such contradictory guidance carries the continuing risk that physical restraint in excess of what is approved or is no longer approved would be used. Also, a multi-disciplinary meeting on 3.2.2015 recommended a referral for a review of physical prompts at meal-times. Based on a review of individual resident's previous history, such prompts may be necessary at times to support that same resident to take his/her medication. At the time of inspection on 27.8.2015 (nearly 7 months later), this review had not taken place. As a result, it was not satisfactorily demonstrated that adequate steps had been taken to eliminate the risk of physical restraint in excess of what was approved in a protocol, being used by staff to administer medication in this centre. Inspectors came to the conclusion that this issue had not yet been satisfactorily resolved and that adequate safeguards were not in place at the time of this inspection.

In addition, the restrictive practice document referenced physical restraint while taking bloods without detailing how this should be carried out.

An inspector reviewed the use of a lap-belt on a chair for another resident. The lap-belt was used for postural and safety reasons and had been recommended by an appropriate professional, in this case an occupational therapist (OT). However, the inspector reviewed an assessment by the OT of the use of the lap-belt and the OT had recommended that the lap-belt only be used when the chair was in a reclined position and that it be released when in the upright position as the resident could then move safely to the floor and move about unrestricted. There was no record in the resident's file demonstrating that the OT's directions were being followed as there was no log of times when the lap-belt was released. An inspector spoke with a staff member who said that the lap-belt was in use any time the resident was in her chair. The staff member said that she was not aware of the OT's directions. Based on the evidence available on the day of inspection, the resident was being restrained in her chair for periods of time during the day when she should have been free to move around. As a result, it was not demonstrated that the restrictive practice was used for the shortest duration necessary.

At the previous inspection, it was found that while permanent staff had received up-to-date training in relation to the management of behaviour that challenges, agency staff (including regular rostered staff) had not. At this inspection, it was found that all staff had since received training in relation to the management of behaviour that challenges. However, two agency staff had not completed training in the protection of vulnerable adults. New staff members were scheduled to attend training. The person in charge said

that staff that had been on leave would complete training on their return to work. The person in charge told inspectors that she was in the process of reviewing any outstanding training and this was also documented in recent minutes from a meeting between the person in charge and CNM3.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
At the previous inspection, it was found that not all restrictions had been reported as required. At this inspection, it was found that all restrictions were reported to the Chief Inspector at the end of each quarter as required.

Judgment:
Compliant

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

Findings:
Following the previous inspection, the provider had outlined in an action plan submitted that all care plans for residents would be reviewed on a continuous basis based on residents' changing needs. During the inspection it was found that healthcare plans were not kept up-to-date. For example, one resident had recently been prescribed continuous oxygen but their healthcare plan had not been updated to reflect this. In another

example there was a 'post-it' note in a resident's healthcare file asking staff to record a particular behaviour. However, there was no reference to this issue in the resident's behaviour management care plan or anywhere else in the resident's file.

Inspectors saw that a referral for an OT assessment had been made for one resident in relation to their mobility. However, a copy of this assessment was not available in the resident's healthcare information. In addition, the resident's mobility assessment had not been updated to reflect this referral.

Judgment:
Non Compliant - Moderate

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:
As was found on the previous inspection, the systems in place for the management of medication required improvement.

The inspectors found that the practice of transcription of medications had improved as the prescription was now being checked by a second nurse.

There was a medication fridge in the treatment room of one of the units The fridge appeared to be in good working order and inspectors noted that the temperature on the fridge was being recorded daily by staff.

Neither prescription nor administration practices were in line with evidence-based practice in relation to medication and patient safety. An inspector observed 'post-it' notes on some prescriptions outlining potential sensitivities that a resident may have to particular medications. These sensitivities were not recorded in the resident's medication care plan or in the drug sensitivities section of the medication prescription record. This carried a risk of life-threatening allergy should the medication be administered.

Judgment:
Non Compliant - Moderate

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:
At the previous inspection, it was found that the Statement of Purpose did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

At this inspection, it was found the Statement of Purpose had been reviewed and revised and now contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Judgment:
Compliant

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

Findings:
There were four actions arising from the previous inspection relevant to governance and management of the centre. While improvements were demonstrated, one action had yet to be fully implemented.

At the previous inspection, it was found that where a person was appointed as a person in charge of more than one designated centre, it had not been demonstrated that he or she could ensure the effective governance, operational management and administration of the designated centres concerned.

Since the previous inspection, a new person in charge had commenced in the centre. Due to the short time-frame that the person in charge was in the role, inspectors were not in a position to determine the effectiveness or otherwise of the new arrangements.

The person in charge is a nurse in intellectual disability nursing and holds a BSc (Nursing). The person in charge has experience in working at clinical nurse manager level. The role of the person in charge was full-time and the post was dedicated to this centre only. The person in charge reports to the CNM3.

Despite being in the centre a very short period of time, the person in charge demonstrated an understanding of key priorities that needed to be addressed, such as care planning and reviewing MDT recommendations. The person in charge told inspectors that she had also held unit meetings in three of the four units since commencing in the role, although minutes had not been kept of those meetings.

The person in charge described the induction that she had received to the centre. This consisted of an introductory session by the CNM3 of 1-2 hours duration, followed by the person in charge participating in an audit of the centre with the CNM3 and provider nominee the week prior to the inspection. The person in charge has had one 1:1 meeting with the CNM3 since she commenced in her role.

The person in charge was however also acting as the house manager for two of the four units while that house manager was on leave. The person in charge told inspectors that she did not yet know the residents that well and knew the residents in the two units where she was also the house manager better than the other two units. The effectiveness of this arrangement was not demonstrated, in particular given the high level of non-compliance in the centre as evidenced in this and previous inspection reports. Also, it was not fully demonstrated that the person in charge had the required supports necessary to enable her to fulfil her role, particularly in terms of nursing and multi-disciplinary input. This is evidenced by gaps in relation to moving and handling, care planning, training and review of restrictive practices. The provider nominee outlined specific supports that will be provided to the centre following the inspection.

Improvement was required in relation to reviewing quality and safety in the centre. At this inspection, improvements had been made in relation to reviewing the quality and safety of care in the centre. This included an unannounced visit and audit by the provider nominee over a two-day period. Auditing of care plans had commenced by the CNM3 and other audits had also been completed, for example, in relation to infection control.

Inspectors found however that further improvement was required to aspects of the management system to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. As discussed under outcome 1, the privacy and dignity arrangements in place were not effectively monitored. As

discussed under outcome 5, the service was still not appropriate to all residents' needs, although steps were being taken to progress this. As discussed under outcome 8 and this outcome, it had not been demonstrated that issues relating to safe provision of the service had not been satisfactorily addressed.

At the previous inspection, failings were identified in relation to the annual review. It was not demonstrated that the annual review of the quality and safety of care and support in the designated centre provided for consultation with residents and their representatives. A copy of the annual review was not made available to residents, their family or representative. Since the previous inspection, the provider demonstrated that steps were being taken to address the failings relating to the annual review within an acceptable timeframe and consultation with residents' representatives had taken place.

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

Findings:
There were two actions arising from the previous inspection relevant to staff training and the provision of nursing care. While it was demonstrated that steps had been taken to address such gaps in line with the previously submitted action plan, both actions had yet to be addressed in full.

At the previous inspection, it was found that given the high medical needs of residents in the centre, it had not been demonstrated how the provider ensured that the number of nursing staff met the assessed needs of the residents.

Since the previous inspection, a new person in charge had commenced in the centre. Recruitment of nursing staff had taken place. At the time of inspection, while posts have been offered to successful candidates, the number of nursing staff in the centre had not increased and so this action had not been implemented in full.

Since the previous inspection, a new household staff member has commenced in the

centre.
At the previous inspection, it was found that all regular staff had up-to-date mandatory training. At this inspection, it was also found that not all training was up-to-date. Two agency staff required training in the protection of vulnerable adults. Training was outstanding for new staff members, although training dates had been scheduled. Training dates for staff who had been on leave had yet to be scheduled, although the person in charge demonstrated that she was reviewing training requirements in the centre.

Judgment:
Non Compliant - Moderate

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:
There were two actions arising from the previous inspection relevant to policies, residents' records and the use of information. At this inspection, some progress had been made in relation to policies, yet the action had yet to be completed in full. The management of healthcare records was not acceptable to the extent that the practices in place created the potential for error. As this issue had been highlighted at the previous inspection.

At this inspection, it was found that the policy on prevention, detection and response to abuse available in the centre still did not adequately address how to respond to anonymous allegations of abuse of residents. A new infection control policy had been introduced to the centre. While a new policy in relation to access to education, training and employment had been developed, it did not address all of the relevant areas as outlined in the Regulations.

At this inspection, it was found that the management of healthcare records required further improvement to ensure that records were accurate, up-to-date, secure and easily retrievable. As outlined in outcomes 11 and 12, information pertaining to medication sensitivities had been written on a 'post-it' note and not in the relevant care plan or in the drug sensitivities section of the medication prescription record. Directions for staff in relation to the need to record specific behaviours were also written on a 'post-it' note attached to the front of the resident's file and not in the relevant care plan or behaviour support plan. The same resident's care plan had not been updated to include information provided from a hospital following the resident's discharge back to the centre. Inspectors found that the poor management of healthcare records in this way was not in line with best practice and created the potential for error.

Judgment:
Non Compliant - Moderate

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:

Julie Hennessy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003944
Date of Inspection:	27 August 2015
Date of response:	23 October 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:
Arrangements required review to ensure that the privacy and dignity of residents was protected at all times.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

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:
The dignity and respect of all service users is being strongly reiterated to all staff by the Nominee provider. The practice of bedroom doors being left open when service users are in their beds or being assisted by staff has ceased immediately on receipt of this report. The Person In Charge has addressed this in all areas and it will be reiterated at all team meetings within the Centre. The Person in Charge, Clinical Nurse Manager 3 and Nominee Provider will do "spot checks" to ensure this practice has ceased.

Proposed Timescale: 26/09/2015

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:
Following hospital treatment medical information did not always inform a plan of care for the resident in relation to identified healthcare needs.

2. 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:
The Person In Charge will ensure that a comprehensive assessment is completed for all service users by an appropriate health care professional, where changes are identified following a hospital treatment or admission. All care plans will be reviewed where changes occur but also no less frequently than on an annual basis. The Person In Charge has scheduled date for care plan reviews for each area within the designate centre. For each area in the centre there are 8 scheduled dates between 05/10/2015 and 03/12/2015 for care plan reviews.

Proposed Timescale: 28/09/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The designated centre was not suitable for the purposes of meeting the assessed needs of each resident.

3. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews were not multidisciplinary.

4. 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:
The Service is on the third recruitment process to employ 2 Psychology posts to support the service users in the centre. To date the service has not been successful in sourcing Psychology support. In the interim both the Heads of Psychology from Limerick and Dublin are dedicating time to the service and the centre. The Chief Executive Officer is actively contacting independent Psychologists to establish contractual arrangements to support the centre.

Occupational Therapy recruitment process is active and the interview process has been complete. Social work recruitment process is active and the interview process has been complete on week ending 25/09/2015.

Proposed Timescale: 30/11/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some equipment used by residents was not being maintained. For example, the handles of some portable commode equipment were observed to be in need of replacement.

5. 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:
The Person In Charge will itemise all equipment in need of repair and refer same to the appropriate supplier or maintenance on site for repair. All repairs will be completed as quickly as possible to minimise disruption and inconvenience to residents. The Person In Charge will allocate responsibility to all key workers to complete regular checks on all equipment and refer to Person In Charge for repair where necessary.

Proposed Timescale: 05/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some parts of the premises were in a poor state of repair. For example, walls and doors throughout each unit had been visibly marked and damaged by wheelchairs.

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:
All walls and doors will be reviewed by the Person In Charge and maintenance manager and where damage to walls/doors requires repair and/or painting is required this will be completed

Proposed Timescale: 02/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not adequately meet the individual need for space of one resident nor did it provide suitable communal space for all residents. In addition, suitable storage was not provided in the centre

7. 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:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The physical design of the centre was poor. Although the bedrooms were all single rooms and all downstairs, 15 of the 31 bedrooms were limited in size. Given the level of physical needs of the residents in one unit, the bedroom sizes presented challenges in terms ensuring the safe moving and handling of residents by staff in such confined spaces.

8. 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:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

Proposed Timescale:

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:
Manual handling techniques were being used which were outdated and unsafe and carried a risk of injury to residents.

9. 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:
The Person In charge will arrange for the Occupational Therapist and manual handling instructor to review all manual handling practices and make recommendations for change where appropriate. These changes will be reflected in all assessments and plans of care and risk assessments will also be updated

Proposed Timescale: 30/10/2015

Theme: Effective Services

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

The system for identifying hazards and managing risks required improvement. Manual handling risk assessments did not always provide adequate guidance for staff. Fire risk assessments required improvement.

10. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
All staff in the centre will receive further training in risk management. This will include the system for identifying hazards, managing risks and completing risk assessments. This training will be delivered by the Quality and Risk Officer.

The Person In Charge and Clinical Nurse Manager 3 in the centre will provide input to all staff in the centre on the risk management policy and the risk management procedure at next team meetings.

Proposed Timescale: 19/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider is required to demonstrate that effective fire management systems are in place. A fire risk assessment with a costed funded plan to address any required improvement works was not submitted to the Authority within a previously agreed timeframe.

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

Please state the actions you have taken or are planning to take:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence of damage to fire doors throughout the building.

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

Please state the actions you have taken or are planning to take:
All doors within the centre will be repaired and painted as necessary. The doors will all be reviewed by the Person In Charge and maintenance manager.

Proposed Timescale: 02/11/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that where restrictive practices were used, they were in accordance with national policy and evidence-based practice.

13. 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:
The Person In Charge and staff team with the Clinical Nurse Manager 3 will review recommendations re all restrictive practices in the centre to ensure that all recommendations are adhered to and that they are in line with best practice. A restrictive practice committee review date of all restrictive practice in place in the centre will be set. The Person In Charge will link with the Chairperson of the restrictive practice committee to arrange same.

Proposed Timescale: 30/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
With respect to the use of a lap-belt, it was not demonstrated that restrictive procedures were used for the shortest duration necessary.

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

Please state the actions you have taken or are planning to take:
The Person In Charge has implemented a recording log to record and monitor the use of a lap belt and to ensure that recommendations made by the Occupational Therapist

are adhered to.

Proposed Timescale: 02/10/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate safeguards have not been put in place in response to allegations of forced administration of medication.

15. 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:
The Nominee Provider has spoken to staff and the Person In Charge in the centre re the manner expected from all employees when addressing any visitor to the centre.

The services of a consultant have been employed to work with the staff team and management of the centre on promoting good practices and a positive attitude to embracing change and enhancing the lives of service users in the centre. This consultancy work has commenced on 24/09/2015.

Proposed Timescale: 30/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two agency staff had not completed training in the protection of vulnerable adults. Training was outstanding for new staff, although training dates had been scheduled.

16. 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:
Since inspection no untrained agency staff have been placed in the centre. All new staff in the centre have scheduled date to attend training on 05/10/2015.

Proposed Timescale: 05/10/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While allegations of abuse at the centre were investigated ,the provider had failed to demonstrate that adequate safeguards had been put in place.

17. 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:
All staff working in the centre will have completed training in protection of vulnerable adults by 05/10/2015. Staff in the centre were met by the Nominee Provider and the Person In Charge after the inspection, and it was highlighted to all that all staff have a responsibility to address everyone they have contact with a respectful manner and also have a responsibility to report any concerns they may have of how a colleague treats a service user or other person in the centre. Informative session was given to all managers by the Nominee Provider and Social Work team on Service User's Protection and Welfare process. At all team meetings since inspection the Person In Charge is highlighting to all staff the need to be vigilant and the reporting system adhered to where concerns of how any service users may be or is witnessed to have been treated inappropriately by a staff.

Proposed Timescale: 25/09/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Healthcare plans were not being kept up to date. Care plans did not direct the care to be given to residents.

18. 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:
The Person In Charge and Clinical Nurse Manager 3 since inspection have set dates and reviewed care plans with staff and key workers. There are eight further scheduled dates for each area within the centre to review all service users care plans. These dates are scheduled to occur between 05/10/2015 and 03/12/2015. All healthcare assessments and plans of care will be updated and contain the necessary information to direct the care to be given to residents. The Nominee Provider met with all staff on the evening after inspection and all use of post-it notes ceased as of that day. Memo re same also circulated from Nominee Provider on 28/08/2015.

Proposed Timescale: 09/10/2015

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:
Neither prescription nor administration practices were in line with evidence-based practice in relation to medication and patient safety.

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

Please state the actions you have taken or are planning to take:
The use of post-it notes across the centre stopped with immediate effect on the evening of 27/08/2015 following information sharing session to staff from Nominee Provider. The Nominee Provider circulated a memo to that effect on the 28/08/2015.

All medication sensitivities will be clearly recorded on the medication kardex and in the service user's medication care plan. The Person In Charge has discussed this with the staff team and the Medication Management Co-ordinator.

Proposed Timescale: 09/10/2015

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:
Further improvement was required to the management system to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. As discussed under outcome 1, the privacy and dignity arrangements in place were not effectively monitored. As discussed under outcome 5, the service was still not appropriate to all residents' needs, although steps were being taken to progress this. As discussed under outcome 8 and this outcome, it had not been demonstrated that issues relating to safe provision of the service had been satisfactorily addressed. Also, it was not fully demonstrated that the person in charge had the required supports necessary to enable her to fulfil her role, particularly in terms of nursing and multi-disciplinary input.

20. 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:

The recruitment process for nursing staff supports is at its end stage and two staff nurses will be deployed to the centre once they are appointed into posts.

While the Person In Charge is new to the centre the Clinical Nurse Manager 3 is providing extra hours of support to the area to support and mentor the Person In Charge and support development of confidence in her role.

The Person In Charge is an integral part of the process and work that the external consultants addressing cultural issue and embracing change with staff are undertaking.

The Nominee Provider and Person In charge have discussed concerns following inspection re upholding dignity and respect for each service user at all team meetings the Person In Charge will reiterate to all staff the practice of doors to bedrooms etc being left open. The Person In Charge will address any issues of this nature that may arise with staff immediately.

Proposed Timescale: 06/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Given the high medical needs of residents in the centre, it was not clearly demonstrated how the provider ensured that the number of nursing staff at met the assessed needs of the residents.

21. 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:
The Director of H.R, the Nominee Provider and previous Person In Charge to the centre had completed a review of staffing to the centre. Part of this review included a review completed by an external consultant in 2013 re staffing to the centre. Additional Staff Nurse posts by two are being deployed to the centre. Recruitment process of same ins now at the final stages.

Proposed Timescale: 06/11/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Mandatory training and other required training was not up-to-date for all staff.

22. 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:
The Person In Charge will ensure that all staff receive and attend dates for mandatory training. A schedule of dates for refresher training where relevant will also be planned by the Person In Charge for all staff in the centre.

Proposed Timescale: 30/10/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At this inspection, it was found that the policy on prevention, detection and response to abuse available in the centre still did not adequately address how to respond to anonymous allegations of abuse of residents. While a new policy in relation to access to education, training and employment had been developed, it did not address all of the relevant areas as outlined in the Regulations.

23. 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:
The Nominee Provider has discussed with the Director of Human Resources the need to have a robust policy in responding to anonymous allegation of abuse of residents. The Director of Human Resources is currently drafting this policy.

The Nominee Provider has discussed the new policy in relation to access to education training and employment with the Quality and Risk Officer, which will be reviewed to ensure it includes all of the relevant areas as outlined in the regulations.

Proposed Timescale: 30/11/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of healthcare records required further improvement to ensure that

records were accurate, up-to-date, secure and easily retrievable.

24. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
All records pertaining to a service user's care and health care needs will be stored in one file, in the centre where the resident resides. Where a clinician has recommended a plan of care this plan and recommendations will be in the relevant section of the service users care plan where the staff in the centre will have also completed an assessment and plan of care. All information, appointment cards etc will be stored in the service user's care plan and will be secure there and easily accessible. No appointment cards or correspondence will be placed outside of the care plan at any time.

The use of post- it notes in the centre has discontinued since the evening of inspection on 27/08/2015.

Proposed Timescale: 30/10/2015