Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005333
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	Thelma O'Neill
Support inspector(s):	Mary McCann
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
15 September 2015 09:30	15 September 2015 19:30
16 September 2015 09:00	16 September 2015 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first inspection of this centre by the Health Information and Quality Authority (the Authority). The purpose of the inspection was to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

The designated centre was managed by the Health Service Executive (HSE) Community Services, Sligo. As part of the inspection, inspectors met with the Director of Services, Area Manager, and Clinical Nurse Manager 2, residents, and staff members. This designated centre provides seven day residential accommodation for nine male residents who have a moderate intellectual disability.

The centre comprises of two houses; the first house was a two storey house with a large secure garden which accommodated four men and the second premise was a bungalow also with a large garden, which accommodated five adult men. All service-users living in this centre were aged between 33- 40 years of age that were

diagnosed with a moderate/severe Intellectual Disability. Two of these service users have a diagnosis of autism, and one has autistic tendencies. These service users display behaviours that challenge on occasions and the service is based around meeting these service-users needs.

The residents gave their consent to the inspector to enter their home and review their documentation. At this inspection, inspectors met with residents, the staff members on duty and the person in charge. Documentation such as personal plans, medical records, policies and procedures and staff files were reviewed as part of the inspection.

Inspectors observed staff interacting with residents in a warm and friendly manner and found that residents had good active lives. Health needs were appropriately assessed and residents took part in a range of activities according to their preference and ability. All residents had their own bedrooms which provided them with privacy and dignity in their homes. Residents were provided the opportunity to access the kitchen and supported to cook their meals and assisted in personal care daily or as required. The houses had two sitting rooms each which provided choice and the freedom for residents to meet visitors in private. Both houses had individual transport available to use as they needed. Both houses were nurse led houses and were supported by a full team of multi-disciplinary members. There was adequate staff support for residents to achieve their daily activities and one resident received support from two staff while out in the community.

Although there was evidence of good outcomes for residents, the inspectors found that there was a lack of effective governance, operational management and administration of the centre as evidenced in relation to restrictive practices, premises issues, risk management, and staffing. This is discussed in more detail under Outcome 14 and examples of this judgment are discussed in the body of the report.

The action plan at the end of the report identifies areas where improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.

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

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

Theme:
Individualised Supports and Care

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

Findings:
There were systems in place for the management of complaints. The centre promoted the Health Service Executive (HSE) National Complaints Policy "Yours Service Your Say" which was available in an easy ready pictorial system for residents and family to access. Residents also had access to an independent advocate. However, the inspectors found that improvements were required in the management of complaints. For example; there were no complaints logged even though inspectors found evidence of dissatisfaction expressed by two relatives in resident's narrative and meeting notes. One parent complained about the shortage of staffing in the centre and another parent complained on two occasions that agency staff were consistently working with her son and were not receiving the appropriate induction required to meet his needs. Following discussion with the Clinical Nurse Manager of the centre, she confirmed to the inspectors that they do not log verbal complaints in the complaints book unless written complaints are received. The inspectors found that there was no evidence that complaints were being actively managed to the satisfaction of the complainant or followed up by the Clinical Nurse Manager responsible for the day to day management of the centre or the person in charge.

Inspectors reviewed the management of residents' money. There were guidelines on the care of residents' property and finances; however there was no policy available in the centre as required by the Regulations. The staff supported residents in the management of their finances; however, this was limited as the residents did not have open access to their Disability payments that were issued to them on a weekly basis. Disability Allowances were managed in bulk accounts by the finance team in the main campus and staff usually requested pocket money for the residents on a weekly/ fortnightly basis or

as required from the Clinical Nurse Manager. Withdrawals and lodgements into the residents petty cash book could only be signed by the Clinical Nurse Manger of the centre and this limited residents free and timely access to their money.

Records of the resident's financial transactions were maintained. There were signatures of the staff on duty for all transactions and a log of all monies received and spent kept in each resident's folder. However, Inspectors found that the centre operated a system of communal monies called a "kitty" to pay for items like food in restaurants, and takeaways. For example; five residents living in one of the houses contributed €20.00 each to the "kitty" most weekends. Over a four week period €300.00 was contributed into the "kitty" There was no record on the receipts or in the log book that the residents that contribute to the "kitty money" had benefited from the purchases, as some residents went home at the weekends. In addition; residents' transactions were not regularly reviewed by CNM 2 or the PIC. A random sample of transactions was audited independently each year by the finance team.

The centre was managed in a way that maximises the residents' capacity to exercise choice and personal independence. There was good evidence of residents being consulted about where and how they wished to live their lives. There was a record of resident's likes and dislikes recorded in their personal folders. There was evidence of residents' meetings regularly taking place to discuss day to day activities.

There were a number of Restrictive practices in place in this centre due to some residents displaying behaviours that challenge. All residents that had their rights restricted had behaviour management plans in place. However, one restriction that was not adequately reviewed by senior management or the clinician in charge of the residents care was the practice of locking a resident into their bedroom at night. This restriction was at the request of the resident and staff said that they wouldn't sleep if the door was unlocked. The inspector found that appropriate safety measures were not in place to safeguard the resident to ensure that all staff members were aware of the Clinicians instructions regarding the procedures surrounding this restrictive practice and that it was appropriately documented and reviewed.

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):
This was the centre's first inspection by the Authority.

Findings:
There was currently no contract of care or written agreement in place between residents and the service to outline the services provided and fees charged. The person in charge commented that she understood that the HSE have produced draft contracts which are currently under review.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The statement of purpose stated that the focus of these houses were to promote community living. Each individual was encouraged to partake in the day to day running of the home. This was facilitated through menu planning, shopping, recycling activities. Social activities include trips to town, cinema, visiting a dog shelter, meals out, walks, day trips etc. The inspectors found that individual service user's wishes were taken into consideration when planning same.

All residents living in the centre had personal plans in place. These plans included information relating to residents' health care needs, communication needs and goals identified. Personal plans generally reflected the assessed needs and wishes of residents; however, while goals were set; there was poor documentary evidence of regular reviews or a system to assess the effectiveness of the plans. In addition; the person responsible for achieving the outcomes was not identified in some instances.

Many of the residents attended separate day services and others received a "wrap around" one to one service from their home. Some people had structured day programmes; others choose what they want on a day to day basis. There was little documentary evidence of meetings between the residential and day services staff to identify the individuals responsible for achieving social goals for the residents. There was no evidence that staff in day and residential services had met regularly to discuss

residents to ensure that all people involved in the resident's lives were kept up to-date in all of the person's health and social care activities.

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):
This was the centre's first inspection by the Authority.

Findings:
The two houses in this centre accommodated up to nine residents. Each of the residents had their own bedroom which ensured privacy and dignity and some residents displayed their personal possessions in their bedrooms and around their home. One premise had ample space to meet the aims and objectives of the service, and the number and needs of residents.

The second house was an older style bungalow that had a number of issues that required review. There were a number of steps outside the kitchen patio door which created a risk for one individual with the visual impairment. There was evidence that maintenance requests were submitted on a number of occasions; however, some of the maintenance requests had not been completed. For example; an environmental assessment had taken place in this house in 2012, as a result of one of the residents being diagnosed with visual impairment. The assessment was completed on the 5/7/2012 identifying 20 environmental issues that required attention to support the resident access and mobilise more freely around their home. To date only 10 of the 20 recommendations have been completed.

A small storage cupboard was used as a storage area for documentation which did not have sufficient space for staff to sit and record information. For example; inspectors found when a chair was used to sit in this space, it extended out onto the hallway and caused a hazard to residents and staff. It was also difficult for staff to access residents' medication and the resident's petty cash and staff had to reach above their head or stand on a chair to access residents' folders.

There was a freezer stored in the residents sitting room, which had been identified as a risk on the risk register and had not been removed. The sitting-room furniture in both houses was in poor repair and required replacement. Leather chairs were damaged and

could not be easily cleaned which created an infection control risk. Diesel fumes from an outside boiler linked to the hot press could be detected in the kitchen when the door to the hot press was opened. There was no carbon dioxide emissions detector in place. Water taps were not temperature regulated, despite being risk rated 12 on the centres risk register.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
A health and safety statement was in place and this was currently under review and there was a risk management policy in place. However, risks identified were not adequately managed. There were regular incidents of peer to peer aggression. There were systems in place to manage adverse events but these required reviews. An accident/incident report was completed when an incident occurred and these were forwarded to the PIC who reviewed them. This information was in-putted onto the services computerised system which captured data on accidents and incidents in the centre and produced a report for each centre. A monthly list of incidents was produced for each house; however, as staff working in the centre could not access the system it wasn't possible for them to review any trends occurring or assess the outcomes of reviews carried out by the PIC to prevent a similar incident re-occurring.

Inspectors found that while individual service-users risk assessments were completed they were not always up to date or reflective of the current level of risk. For example; there was one incident where a resident had recently displayed serious aggression towards a person while out for a walk in the community, which resulted in injury to the person involved. On review, this resident's risk assessment had not been reviewed to reflect the changes in the level of risk following this incident or to update additional control measures to prevent further incidents occurring in the future.

Inspectors also found where clinical risks were identified for individual service-users, such as the risks associated with epilepsy; the individual's risk assessment contained contradictory advice in their file; as to whether it was compulsory for the staff to complete training prior to administering the emergency medication. In addition; there was no protocol for the administration of emergency medication to, guide staff as to the correct dosage of medication, or what to do if a seizure occurred when out in the community.

Staff were trained in fire evacuation procedures, and fire exits were observed to be unobstructed and there were records of day and night time checks of each fire exit. A fire drill had recently been carried out and these were occurring regularly, but the fire drills did not detail how many people participated in the drill, or if any impediments to safe evacuation was identified.

All residents had a PEEP (personal emergency evacuation plan) however, one resident PEEP was found to be contradictory for example, the PEEP stated "resident has no concept of danger" and then states "resident will not re-enter the building until it is safe to do so" As the resident was unaware of danger, there was no assurances that the resident would not enter the building..

Inspector saw a fire safety report commissioned by the provider and completed by an external fire consultant in January 2015 that identified areas of high and medium fire risks in the centre. The report recommended that some issues be prioritised and recommended that high risk issues be resolved within 3-6 months. However, to date this work had not yet commenced to resolve the fire risks.

A policy was available on the prevention and control of infection, but staff had not yet completed infection control training. The inspector observed that the centre had a risk register, which identified that the organisation was potentially in breach of Data Protection legislation, which was risked at the highest level of 20; as resident's personal and medical information was being transferred via email on an insecure email server. The managers said they were aware of the risks of breaches of confidentiality regarding residents' private information and despite I.T. consultants reviewing the issue; they were unable to rectify the situation to-date.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:

The inspector found there were systems in place to protect residents from the risk of abuse. However, there was a significant amount of peer to peer aggression and resident to staff aggression recorded in the centre. While staff had taken measures to minimise the incidents or risks to residents and themselves as staff, there was no evidence that a discussion had taken place around the suitability residents placements in this centre as a measure of reducing the incidents of aggression in the centre and this requires review.

Staff spoken to were knowledgeable with regard to what constituted abuse and stated they would report any suspicion or allegation of abuse immediately to their manager or senior person on call. Staff had received training in safeguarding vulnerable adults. There was one Trust in Care investigation ongoing in the centre at the time of the inspection. The person involved is not working with vulnerable adults and is currently on administrative duties pending the outcome of the investigation. The inspectors received assurance from the provider nominee that all residents have been protected and the organisational procedures are being followed as per the adult protection and safeguarding policy.

There were a number of restrictive practices in place at the time of this inspection related to the locking of doors in the house and restrictions relating to travelling in the car or when out walking in the community. However, these restrictive practices were not always identified in behaviour support plans and there were no reviews of these restrictive practices by the multi-disciplinary team documented. There were a number of residents with behaviours that challenge accommodated in the centre. Staff described good access to mental health services, and one resident had access to a private consultant psychologist who reviewed the resident every three months. However, there was evidence that the recommendations of the consultant psychologist were not updated in the resident's behaviour support plan to ensure all staff were consistent in their approach. Also there was evidence that there was a delay of over two weeks in accessing the Behaviour Support Therapist following a serious incident involving a person being injured while out walking in the community.

Judgment:
Non Compliant - Moderate

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):
This was the centre's first inspection by the Authority.

Findings:

Most service-users attended day programmes based in the campus services 4- 5 days a week and other service-users availed of day programmes from their community houses. Others residents activities involved trips to the dog shelter, recycling activities,walks and horticulture activities.

While service-uses had transitioned to live in the community from the campus settings; most residents continued to receive their social activities programme from campus and there was no evidence that residents had community transitional plans in plan in place to fully integrate service-users to participate in day activities in their local community. There was no assessment or plans in place to support community training programmes.

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):
This was the centre's first inspection by the Authority.

Findings:
Residents' health care needs were met with appropriate input from medical services and allied health professionals. Staff reported that all residents were healthy at the time of inspection. Staff described a good working relationship with the local General Practitioners and an out of hour's service was also available. Services to include physiotherapy, speech and language therapy, occupational therapy, dental, chiropody, mental health and dietetics are available via referral to the HSE. The manager and her team work in collaboration with a team of Multi-disciplinary supports such as Psychiatrist Behaviour Therapist, Social Worker, to support service users and their families. The staff team assist the service users to live and integrate as fully as possible into their local communities.

Residents' nutritional needs were met. Regular weights were recorded and reviewed monthly to ensure weight loss or gain was noted. Residents cooked their meals from home with the assistance of staff. Staff told the inspector that they regularly brought residents out for tea and often enjoyed lunch at the weekend in local restaurants as part of a social outing. Snacks and drinks were freely available.

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):
This was the centre's first inspection by the Authority.

Findings:
All medications were administered by nursing staff, but on the day of inspection there was no nursing staff on duty in the house, so a staff nurse from another service area in the main campus was called to administer the medication to the residents. The care staff told inspectors that they were not yet trained in administering the medication in this house. This is actioned under Staffing in Outcome 17.

No resident was self-administering their medication at the time of this inspection. Each resident's medication was supplied in a blister pack. These were stored in a locked medication cabinet. The inspector reviewed the prescriptions and medication administration records and found that they were clearly written and complied with best practice with a signature of the prescribing doctor for all medication administered and a date and signature for any medication discontinued. The maximum dose prescribed for as required (PRN) medications was stated on the medication charts. However, inspectors found inadequate guidelines for staff to follow such as a protocol for the administration of emergency medication for the treatment of epilepsy to, guide staff as to the correct dosage of medication to administer, or what to do if a seizure occurred when out in the community.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:
Inspectors found there was a lack of effective governance, operational management and administration of the designated centre. The Area manager for this centre is responsible for four designated centres (24 houses) in the community and was also currently identified as the Person in charge, for three of these designated centres (19 houses). She was supported by a Clinical Nurse Manager 2 whom manages the centre on a day to day basis. At the time of inspection the governance and management arrangements were under review, and the Authority was notified on a number of occasions of suggested re-configurations as to the governance arrangements. However, the inspectors were advised subsequent to the inspection, that due to Industrial Relations issues, the proposed CNM managers will not take up the role of PIC as advised.

The Clinical Nurse Manager 2 (CNM2) responsible for this centre manages this and three other services on a day to day basis. Care is supervised by Register Nurse's in Intellectual Disability (RNID) who are responsible for developing and delivering the individual care plan, and working in collaboration with a team of Multi-disciplinary supports such as Speech and Language Therapist, Behaviour Therapist, Social Worker, Psychologist to support service users and their families. The staff team assist the service users to live and integrate as fully as possible into their local communities.

The Clinical Nurse Manager 2 told inspectors that she speaks to staff daily via telephone and meets with staff from each house every couple of days. In addition, team meetings are held once a month. However, governance issues that required review were the lack of regular staff in the house and the daily reliance on agency staffing which had not been adequately addressed. Risk assessments were not regularly reviewed and control measures put in place following serious accidents/incidents. There were inadequate protocols around restrictive practices and the administration of emergency medication to residents and serious data protection issues were not addressed.

The Clinical nurse manager 2 and Area Manager/PIC were not monitoring the centre sufficiently and the person in charge told inspectors that she was unable to visit each of the 19 house's regularly due to her other work commitments. There were further areas of non-compliance with the Regulations which included the lack of an annual review of the safety and quality of care provided to residents. The inspectors found that the Area Manager/ Person in Charge was not actively engaged in the day to day management of the centre, this was further evidenced by the fact that the most recent entry in the centres visitor's book by the person in charge on the 3/6/15

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the

needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Inspectors reviewed the staffing levels allocated to meet the residents assessed needs, and found that there was adequate staffing in the centre. However, it was clear that there was an inconsistency of regular staff working in the centre. Agency staff were consistently used in one house to cover two twilight shifts and this created anxiety for one resident, and whose parent had made a complaint as to the effect this was having on her son. The Clinical Nurse Manager 2 told inspectors that the difficulty in staffing the service was due to the lack of locum staff working in the organisation and most staff replacements were provided by an external staffing agency.

The staff rota did not reflect the actual staff on duty, for example; night staff were not recorded on the staff roster. In addition; staff did not have training in safe moving and handling, studio thee, or hand hygiene or risk management and this required review.

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:

Thelma O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005333
Date of Inspection:	15 and 16 September 2015
Date of response:	18 December 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:
Appropriate protocols and safety measures were not in place to ensure the residents rights were maintained while restrictive practices were in place.

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:
•Protocols and safety measures will be put in place to ensure the rights of residents are maintained in relation to restrictive practices.
•Staff training and awareness around rights restrictions will be delivered under the guidance of the psychology services.
•All restrictive practices will be reviewed, monitored and discussed at the rights restriction forum lead out by the psychological services.
•Resident's privacy and dignity will be 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.

Proposed Timescale: 31/01/2016

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no policy available in the centre to guide staff in managing residents' money.

The residents did not have open access to their Disability payments that were issued to them on a weekly basis.

The procedures in place regarding withdrawals and lodgements into the residents petty cash book limited residents free and timely access to their money.

The system of communal monies called "kitty" money lacked appropriate supervision and monitoring.

2. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
•Arrangements for Residents to access their disability payments will be put in place by opening individual post office accounts for all residents, with the support of the finance team.
•The kitty has been discontinued 16/09/2015; all residents now access their own money while shopping and are supported by staff.

•There will be no longer a delay for Residents in the withdrawal/lodgement of their personal finances. Access to their funds will be available to them at all time through the post office and residents will be supported to lodge and withdraw their own money with

their key worker.
•The Capacity for a number of residents will always require a level of Guidance & Instruction in relation to their finances.

Proposed Timescale: 31/01/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Complaints were not appropriately recorded and there was no evidence that the complaints were appropriately managed.

3. Action Required:
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

Please state the actions you have taken or are planning to take:
•Complaints Log to be included in front of Complaints folder to identify outcome of complaints.
•Complaints Log Form has being updated to determine if complainant is satisfied with the outcome.
•Complaints will be appropriately recorded and managed. The importance of recording and reporting both verbal and written complaints in a robust and timely manner will be addressed with Staff,
•Scheduled Monthly Complaint Review meetings will take place within the community and with the PIC to ensure complaints are managed appropriately and in a timely fashion. A letter of closure will be issued to the complainant when the complaint is resolved.

Proposed Timescale: 31/01/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person who managed complaints did not ensure that complainants were informed of the outcome of their complaint.

4. Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
•Complaints Log to be included in front of Complaints folder to identify outcome of complaints.
•Complaints Log Form has being updated to determine if complainant is satisfied with

the outcome.
•The person who manages complaints will ensure that complainants are informed of the outcome of their complaint.
•The complainant will be kept informed as to the status of their complaint, on resolving their complaint a letter of Closure will be sent to the Complainant and placed on the Residents file. A log of all complaints will be maintained in the Designated Centre by the PIC.

Proposed Timescale: 01/12/2015

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:
There was no contract of care or written agreement in place between residents and the service to outline the services provided and fees charged.

5. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
•An agreement for the provision of services including the support, fee, care and welfare of the resident and details of the services to be provided for that resident where appropriate will be provided.
•Contract of Care has been issued to all families of Residents in this designated centre.
•Contracts of Care to be looked at in more detail in relation to services being provided to the residents & families to be updated.

Proposed Timescale: 26/02/2016

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 was poor documentary evidence of regular reviews or of a system to assess the effectiveness of the personal plans.

The person responsible for achieving the outcomes was not identified in some plans reviewed.

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

Please state the actions you have taken or are planning to take:
•Documentation and reviews around personal plans will be reviewed in line with regulation 05 (7).

•A Collaborative approach will be established to ensure that resident's goals are agreed and persons identified to support the individual to achieve their goals.

•Review of Goals will be in collaboration with Day Services for all residents whom attend a day service and communication strategies will be devised to improve effective services.

•Communication Workshop with SALT to be rolled out across the service for adults with significant communication difficulties related to ASD.

•Recommendations arising from personal plans will be followed up and changes to plan documented accordingly.

•Person will be identified for goal planning, implementing and time scales agreed for achievement of goals, goals will be evaluated following achievement and new goals will be agreed in consultation with the resident.

Proposed Timescale: 12/02/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was little documentary evidence of collaborative workings between the residential and day services staff, who was responsible for achieving social goals for the residents.

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

Please state the actions you have taken or are planning to take:
A Schedule of review meetings will be drawn up for residents, and will include staff from the day service to attend on a quarterly basis to review progress and goal planning/achieving, so that all the people involved in the person's life will be kept up to date in all aspects of the persons health and social care activities. This will include the Multi-Disciplinary Team together with Day services and residential services and family.

Day service staff will be identified where possible for supporting goal achievement and will sign off on document accordingly.

Proposed Timescale: 31/12/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were a number of steps outside the kitchen patio door which created a risk for one individual with the visual impairment.

Ten maintenance requests had not been completed despite being identified in 2012.

Fumes from an outside boiler linked to the hot press, could be detected in the kitchen when the door to the hot press was opened.

There was no carbon dioxide emissions detector in place as a safety precaution to identify excessive odours were a risk to the health and safety of the residents.

Water taps were not temperature regulated, despite being risk rated 12 on the centres risk register.

A small storage cupboard was used as a staff office which did not have sufficient space for staff to sit. A chair used extended out onto the corridor and caused a hazard to residents and staff.
It was difficult to access resident's medication and the resident's petty cash and staff had to reach above their head or stand on a chair to access residents' folders.

There was a freezer stored in the resident's sitting room, which had been identified as a risk on the risk register and had not been removed.

The sitting room furniture in both houses was in poor repair and required replacement. Leather chairs were damaged and could not be easily cleaned which created an infection control risk.

8. 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:
•The steps at the Patio are supported by a hand rail and are painted to support the resident with a visual impairment; the back door step will be replaced by a ramp and a support rail to ensure the safety of all residents in the home in particular the resident with visual impairment.

•A Quality improvement plan will be devised with the staff and the maintenance team to carry out all essential repairs and renovations to the house as identified Minor Works Capital has been submitted to HSE in relation to this; awaiting approval for funding by 29/04/2016.

•A carbon monoxide emissions detector has been put in place in the home as a safety precaution to identify and alert staff to excessive odours that may put the health and safety of residents at risk.
•Water taps are now temperature controlled in both houses with the exception of one shower; this will be completed by December 2015.
•The office space for staff in one house has been notified to management and PIC, a business plan has been submitted for funding to carry out minor works to the home to provide staff with a safe office space to access resident's medication and files. Awaiting approval for this funding by 29/04/2016.
•The freezer has been removed from the residents' sitting room and is no longer a risk. This risk has been closed on the risk register.
•Requisition for the purchasing of new furniture has been submitted and will be replaced.

Proposed Timescale: 31/01/2016

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:
Risks identified of peer to peer physical abuse were not adequately managed.

Systems in place to manage adverse events required reviews.

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:
•Risks identified will be dealt in a robust and timely manner.
•Staff training in relation to Risk and Safeguarding will be updated and monitored, all incidents of peer on peer abuse will be discussed and reviewed with the psychology services and managed accordingly.
•There will be systems in place to measure and ensure actions are recorded and controls of risks identified.
•There will be monthly review of the risk with the team, PIC and the IRG group to discuss the learning's.
•Local Risk Register will be updated Monthly to commence immediately.
•All behavioural plans will be updated by the behavioural therapist.
•Individual Incidents will be risked assessed and updated as required; these will reflect level of risk following incidents and controls put in place to prevent further Incidents

taking place.
•There will be a protocol on the administrating of emergency medication which will guide the staff in the event of a seizure at home or in the community.

Proposed Timescale: 31/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Individualised service-user's risk assessments were not always up to date and did not reflect the current level or potential risks associated with particular activities the individuals liked to undertake.

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

Please state the actions you have taken or are planning to take:
•A review of all the risk assessments in the designated area will be carried out. A review of all behavioural plans will be carried out under the guidance of the psychological services

•Fire Drill form will be updated and will indicate start and finish times, who attended and the learning identified and shared. Drills will be planned at various times and will be organised both day and night, and the use of house alarm once a month will be carried out to familiarise residents of the alarm in the home.

•Supervision and support for residents will be clearly stated in their individual PEEP plans.

•Work identified in the Maurice & Johnston fire report will be commenced by 31/12/2015

•Infection control training will be carried out with all staff in the designated centre by end of first quarter.

Proposed Timescale: 31/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre's risk register identified that the organisation was potentially in breach of Data Protection legislation, as resident's personal and medical information was being transferred via email on unsecure emails.

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

Please state the actions you have taken or are planning to take:
•All communication via g mail has stopped in both houses and the homes are no longer in breach of Data Protection Legislation.
•No personal information in relation to residents is being transferred via email.
•IT plan will be put in place to address the issue of communication with staff and the passing on of information. The IT Policy will be distributed to all staff. Business case will be submitted to Management around the office space required for one of the houses.

Proposed Timescale: 23/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff had not completed infection control training.

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

Please state the actions you have taken or are planning to take:
All staff in both homes will receive Infection Control training in the first quarter of 2016.

Proposed Timescale: 31/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire safety risks had still not been appropriately addressed, despite being identified as high risk in a consultant's report in January.

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

Please state the actions you have taken or are planning to take:
•All recommendations from the consultant report on fire, with regard to fire equipment,

maintenance, building fabric and building services will be commenced by 31/03/ 2016.
•The Maurice & Johnston Report will be attached to this action plan
•All immediate risks identified through the inspection are addressed.

Proposed Timescale: 31/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence that staff were not appropriately trained in assessing residents' personal emergency evacuation plan's as, one resident' s evacuation plan was contradictory and unclear.

14. 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:
•All PEEP forms will be updated to ensure that evacuation plans are clear and residents needs are been met during evacuation.
•PEEP plans will clearly indicate residents' individual needs when evacuating. All staff will be trained in fire and evacuation technique as per policy.

Proposed Timescale: 31/12/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices were not always identified in the behaviour support plans, and there were no reviews of these restrictive practices by the multi-disciplinary team.

Recommendations of the consultant psychologist were not updated in the resident's behaviour support plan to ensure all staff were consistent in their approach.

15. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
•Recommendations from consultant psychologist have been followed up in October

2015 and discussed and signed off in relation to one home. These recommendations have been up dated in residents file and all staff will be trained on December 10th 2015 in relation to consistency in approach, autism and behaviours that challenge.
•All documents will be signed off by Management and Staff following on from review of Behavioural plans, restrictive practices in particular to one Resident who wishes to lock his door. Family will be included in all decisions around restrictive practices.
•System in place in relation to referral to Psychology & use of restrictive practice procedures. This is being led out by Senior Behavioural Psychologist.

•Restrictive practices will be identified within the homes with the support of Psychology services and MDT.
•Staff awareness in relation to restrictive practices will be updated and monitored, all restrictive practices will be discussed and reviewed with the psychology services and managed accordingly.
•There will be systems in place to measure and ensure actions are appropriate.
•There will be monthly review of restrictive practices with the team, PIC and behavioural therapist to discuss the learning's.
•Consultation with Senior Behavioural Psychologist will take place by means of Referrals & MDT meetings
•We shall be continuing with NRS to fill the post of Senior Behavioural Psychologist. The present Psychologist has agreed to attend Cregg Services x 1 day per week. Psychology Assistants x 2 will remain as a support to the team

Proposed Timescale: 31/01/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that there was a delay of over two weeks in accessing the Behaviour Support Therapist following a serious incident involving a person being injured while out walking in the community.

16. 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 PIC will ensure that every effort to identify and alleviate the cause of residents' behaviour is made and supported by the MDT. Alternative measures will be considered before a restrictive practice is implemented. Where a restrictive practice is necessary, it will be as a last resort, for the shortest duration, recorded and monitored and all incidents of restrictive practices will be acted on immediately.

•In the absence of Behavioural therapist other disciplines will be contacted immediately to discuss the restriction. There will be a proactive approach when dealing with

Behavioural issues in this designated centre.

•NIMS policy will be adhered to within the service.

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not sufficient review of the control measures and preventative actions required to address the consistent peer on peer aggression in the centre.

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:
•Staff training in relation to Risk and Safeguarding will be updated and monitored.
•All incidents of peer on peer abuse will be discussed and screened/reviewed with the psychology services and designated officer in line with the National Safeguarding Policy.

•There will be systems in place to measure and ensure actions are appropriate to control risks identified. There will be monthly reviews of incidents with the team, PIC and the IRG group to discuss learning.

•Monthly update of Local Risk Register in this designated centre.

Proposed Timescale: 31/12/2015

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:
Residents moved to community residential services did not have their educational, employment or training goals assessed and community integration programmes were not developed for all residents.

18. 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:

•Transitional plans and community mapping will be researched for all residents in relation to educational, occupational and day service activities within their local communities.
•Residents will be supported and encouraged to facilitate work, social integration and education where appropriate and at the choice of the resident in their local community.
•Transitional plans will be developed with the individual, MDT, staff and families to facilitate this process if required.

Proposed Timescale: 31/03/2016

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:
There was no protocol for the administration of emergency medication to treat a patient in an epileptic seizure, or to instruct staff as to the correct dosage of medication.

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:
•There will be protocols put in place for the staff training and the administration of emergency medication to treat an epileptic seizure, to instruct staff as to the correct dosage of medication and what to do if a seizure occurred when out in the community. Epilepsy Ireland will train staff in this area.
•Training in relation to Safe Administering of Medications has been organised for December 14th and 15th 2015 and subsequent training thereafter.

•It will be Mandatory to have all staff to complete this training.

Proposed Timescale: 28/06/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The role and responsibility of the Services Area Manager in managing 24 houses in the community did not lend to them to be able to incorporate the role as person in charge for more than one designated centre.

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

Please state the actions you have taken or are planning to take:
•The role and responsibility of the Services Area Manager will be reviewed to ensure effective governance, operational management and administration of the designated centre.
•Management systems will be reviewed in the designated centre to ensure that the service provided is safe, appropriate to the residents needs and monitored effectively by the current/temporary PIC up to 30/06/2016 when PIC for this service will return from leave.
•A schedule will be developed to ensure regular announced and unannounced visits by the PIC and Area Service Manager to ensure safety and quality of care.
•Regular minuted team meetings with identified time framed actions and person responsible will be scheduled which the PIC and Service Area Manager will attend.
•A formal handover of service will be arranged when PIC returns from leave 30/06/2016

Proposed Timescale: 30/06/2016
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Area Manager/ Person in Charge was not actively engaged in the day to day management of the centre, This created risks to residents and staff.

21. 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:
•Management systems will be reviewed in the designated centre to ensure that the service provided is safe, appropriate to the residents needs and monitored effectively by the current PIC up to 30/06/2016 when PIC for this service will return from leave.
•A schedule will be developed to ensure regular announced and unannounced visits to ensure safety and quality of care.
•Regular minuted team meetings with identified time framed actions and person responsible will be scheduled which the PIC and Service Area Manager will attend.
•A formal handover of service will be arranged when PIC returns from leave 30/06/2016

Proposed Timescale: 30/06/2016
Theme: Leadership, Governance and Management

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

22. Action Required:
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
There will be an annual review completed by the provider on the safety and quality of care provided to residents in this designated centre.

Proposed Timescale: 31/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to complete an unannounced visit to the designated centre on a six monthly basis.

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

Please state the actions you have taken or are planning to take:
•The provider will complete an unannounced visit to the designated centre in the next 6 weeks.

Proposed Timescale: 31/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of consistency in the rostering of staff working in the centre.

24. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of

care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
Consistent staffing and holiday relief is present in this service on day and night duty.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The actual and planned staff rota did not reflect the actual staff on duty. There was no night staff identified on the staff rota.

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

Please state the actions you have taken or are planning to take:
Rosters have been updated and now reflect both Day and Night Staff in a 24hr period.

Proposed Timescale: 01/12/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received mandatory training as directed by the organisation and the regulations.

26. 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 plan has been devised with Management and staff to deliver all Mandatory training for all staff in this designated centre to attend.

•All staff will have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Proposed Timescale: 31/03/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised and support measures put in place to adequately address risks identified in the centre.

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

Please state the actions you have taken or are planning to take:
•Staff will be appropriately supervised and support measures put in place to adequately address risks identified in the centre, using the performance management framework.
•The clinical nurse manager/PIC and Area Service Manager will visit the house on a regular basis offering support and guidance to staff in relation to risk as required.
•Regular minuted meetings with time framed actions with person responsible will be introduced to the houses carried out by the CNM2. Schedule to be devised for same; PIC and Area Service Manager will attend.

Proposed Timescale: 31/01/2016