

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002967
Centre county:	Meath
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Philomena Gray
Lead inspector:	Sonia McCague
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	1

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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 November 2015 09:30	10 November 2015 18:00
11 November 2015 09:30	11 November 2015 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
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 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the centre’s second inspection by HIQA. The purpose of this announced inspection was to inform a decision of registration under the Health Act 2007 following an application to register the centre as a centre for five adults with a disability. The action plan response following the triggered unannounced inspection carried out 27 and 28 July 2015 was also followed up.

Based on the number of non-compliances and findings of this inspection and the needs of the existing four residents, the application and intention to accommodate five residents required review and due consideration by the management team in line

with the available resources, improvements required, the statement of purpose and function of the centre and those already accommodated.

The centre was accommodating four residents, three male and one female, in a rural detached two-storey dormer style house that had accommodated up to five residents previously and prior to the last inspection.

A self contained and separate onsite building with day/activity space, kitchen, sanitary and utility facilities was also available. Residents did not attend other day services. Entry to and exit from the grounds of the premises was controlled by staff by key coded gates.

The provider nominee, the programme manager who was deputising for the person in charge and the social care leader met with the inspector at the commencement of the inspection and all attended feedback in relation to the findings. The social care leader facilitated the inspection throughout.

While the staff team had brought about improved outcomes for residents, many areas required improvement which included providing adequate resources to meet the needs of residents, staff training and skill mix, risk management, safeguarding and safety, medication management, operational policies and procedures and other matters outlined within this report.

Thirty nine breaches in the legislation are required to be addressed by the provider and person in charge in order to ensure compliance with Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities.

The provider has 22 regulatory requirements to address and the person in charge has 17 action requirements.

Interviews to determine the fitness of the persons participating in the management of this centre are to be conducted as part of a registration process following receipt of the action plan response.

A recommendation for registration will be dependent on the provider and person in charge's response to the action plan where improvements are discussed within the body of this report and outlined at the end in the action plan for response.

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 inspector found that arrangements were in place to promote the rights, privacy and dignity of residents and choices were encouraged. Further development of staff was required to ensure the centre is operated in a manner that respects resident's gender, intimate care needs, disability, family status, right to advocacy and consent.

Procedures were described and in place to promote and ensure residents are consulted with, and participate in, decisions about their care and about the organisation of the centre. However, gaps in the available documents to demonstrate arrangements and engagement was found that required improvement.

Procedures and arrangements in relation to respecting and evaluating the rights of residents, that included access to a rights review committee, were included in policy documents. The inspector observed that staff on duty provided care to the residents with dignity and respect.

Access to national advocacy services and information about residents' rights were available and information and contact details were on display in the centre. A dedicated advocate within the local region was to form part of the support services to be made available to each resident by the end of November 2015 to address the action required and response received following the last inspection.

Arrangements were in place to promote and respect residents' privacy and dignity, including receiving visitors in private. Resident meetings formed part of the arrangements for consultation and decision making processes.

Procedures and arrangements were in place and described by the staff team to enable residents to exercise choice and control over their life in accordance with their preferences and to maximise their independence. However, the preference of a female resident to be supported by female staff was not provided consistently.

While the inspector was informed by staff and read in a resident's care plan that they had access to their own money (weekly allowance) and were supported by staff to go to the local post office to carry out money transactions, the inspector was informed that arrangements in relation to transactions or deductions from residents' bank account/s were not managed by, known or accessible to staff working in the centre. This is further referenced in outcome 4.

A complaints policy was in place. The complaints procedure was displayed and an easy read version was also available. A dedicated log book for recording complaints was present. There were no complaints logged or reported by staff since the last inspection.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

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

Findings:

There was a corporate policy on communication; however, improvements were required in the policy to describe arrangements and practices relating to this centre. This is included the action plan of outcome 18.

The inspector found that arrangements were in place and described by staff so that residents were supported and assisted to communicate in accordance with their needs and preferences. A speech and language therapist was available within the multidisciplinary team and the inspector was informed they were due to visit the centre later in the week of the inspection to provide an information session to staff.

However, residents' communication needs were not sufficiently identified in the assessment and personal planning process. Gaps in the assessment documentation in relation to assessments undertaken and means of communication to be adopted were found and records did not capture individual communication limitations, abilities and support requirements. This is reported in outcome 5.

A separate communication folder with information on each resident was available to reflect the requirements and supports necessary for communicating with residents.

Residents of the centre were being supported to form and develop links with the local and wider community. Residents had access to radio, television, and information on complaints and emergency procedures. However, Internet access was not available during the inspection. This deficiency was reported by staff as a recurrent problem that had been previously escalated to management and that required immediate attention as all information on residents such as data contained on a shared drive/folder was not accessible as required.

Access to an Ipad was available. The inspector was informed that one resident was being supported to develop the necessary skills and use of assistive apps with a goal to buy and have their own Ipad by the end of November 2015. Access to assistive technology, aids and appliances where required are to be made available to promote residents' full capabilities and facilitate needs.

Judgment:

Non Compliant - Moderate

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Based on the information available and based on discussions with staff, the inspector was satisfied that family, personal relationships and links with the community were encouraged and promoted. However, documentation to demonstrate the arrangements and engagement with family and other professionals involved in the care and welfare of residents was lacking and not sufficiently maintained in the centre. This was included in the action plan for outcome 1.

A policy in relation to visiting residents in the centre was not available and this is included in the action plan of outcome 18.

However, staff told the inspector that they supported residents to receive visitors in private and family visits. Family visiting arrangements was generally known, routine or arranged in advance to suit the needs of residents.

The inspector was informed that residents were being supported to develop and maintain personal relationships and links with the wider community as part of their personal plans and goals. The social care leader showed the inspector a copy of a letter sent to all residents' families/representatives in September 2015 to encourage their involvement in the lives of residents in accordance with resident's wishes. Information contained within the letter included details of an advocacy group contact details and an opportunity to voice concerns in relation to the service that was offered.

The inspector was informed by staff that all residents' families and representatives of residents are invited to attend personal plan meetings and periodic multidisciplinary reviews in accordance with the wishes and needs of the resident.

The inspector was informed by the programme manager and social care leader that residents would be supported with staff and transport arrangements to promote family engagement. Families were to be informed or reminded by the team of the resources/opportunities available to them to facilitate their engagement.

Judgment:
Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:
Effective Services

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

Findings:

There were policies and procedures in place for the admission process that included transfers, transitions, discharges and the temporary absence of residents. The admission procedure included a process of preliminary screening with inclusion and exclusion criteria to inform the admission, transition and or discharge process. Defining and understanding the determining factors for the exclusion criteria outlined such as those with high medical needs was unclear to all staff. Therefore, the policy and procedures lacked transparency as required.

No residents were admitted, transitioned or discharged since the last inspection. The inspector was told that residents' admissions were decided at a senior level that involved the person in charge or their deputy, the residential coordinator and others.

The programme manager and social care leader told the inspector that admissions and or transitions would be facilitated in accordance with residents' wishes and transparent procedures that considered the wishes, needs and safety of the individual and the safety of other residents living in the shared accommodation and services.

The inspector was informed that emergency admissions were not facilitated which is reflected in the statement of purpose and function.

A draft contract of care ('think ahead') and financial support agreement document was available outlining some terms and conditions of services to be provided. However, these documents were incomplete and did not include all details of the services including the fees charged and or deducted from resident personal accounts. The documents had not been signed as agreed by the resident or their representative.

This action from the last inspection was to be completed by 31 October 2015. The management team told the inspector that the provider plans to finalise and complete a written contract of care with each resident with the terms of their stay in the centre to include an easy read version.

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:

The inspector found that arrangements were in place to develop and promote the social care needs of residents. Activities and practices described by staff demonstrated an improvement in their approach to support residents' assessed needs, goals and wishes. Improvements were attributed to the allocation of up to two key-workers to support each resident and consistency in agency staff providing support to residents along with the recruitment of additional core staff. However, improvements were required.

The admission, review and assessment procedures included a process of health screening and social assessment. However, as outlined in outcome 2, the records available were incomplete and did not demonstrate that a comprehensive assessment or review had been maintained to identify needs, abilities and changes to inform a personal plan to ensure the arrangements and interventions were put in place to meet the assessed needs of residents and aid evaluation.

The inspector was informed that the assessment and personal plan documents available had been introduced since the last inspection with the aim of capturing all of the individual needs and abilities of residents. While assessment documents were signed off and in use in practice they were incomplete in many sections that resulted in a breakdown in communication and disconnect in the transfer of specific information that included the input of internal or external appointments and assessment recommendations, and where necessary, the requirement of a referral or follow-up. Residents' communication needs were not sufficiently identified in the template to inform an assessment and the personal planning process.

The inspector read residents' records and was informed by staff of residents' needs, goals, abilities and aspirations. The templates available were in an accessible illustrative and easy-to-read format. However, the social care supports to include specific and measurable interventions had not been sufficiently reflected in the personal plans reviewed.

Arrangements were described and records were available to demonstrate that residents, along with their key workers, were actively involved in identifying residents' individual goals and plans.

Assessments available on files pertaining to residents included multidisciplinary input and review. However, records containing concerns raised by multidisciplinary professionals in meetings held in the previous months in relation to one resident's weight gain and the recommendations to access a dietician had not been appropriately acted upon or completed to ensure appropriate assessment, monitoring and development of a specific plan of care.

The inspector was informed that residents and their family members or representatives, where appropriate, were consulted and involved in the review of plans. However, this involvement was not reported by relatives of one resident and not consistently recorded to confirm these arrangements.

Planned supports, such as familiar staff and key records of information, were described to form part of the process when residents transfer between services or attend medical review meetings or professional appointments. However, improvements were required in relation to the records available and maintained by professionals in relation to the assessments or reviews undertaken, and prescription changes and decisions made. This is further discussed in outcome 12 and outlined in the action plan of outcome 18.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The inspector found that the location, design and layout of the centre was suitable for its stated purpose and aimed to meet residents' individual and collective needs in a comfortable and homely way.

There were appropriate facilities and the layout aimed to promote residents' safety, dignity, independence and wellbeing. The required actions in relation to the premises from the last inspection had been progressed or addressed.

The centre comprises of a two-storey house, which was suitably furnished and fitted for occupancy by the four residents accommodated.

A vacant room intended as a bedroom was available on the ground floor. On examination of this room, the inspector observed a large wall painting or mural with brightly coloured underwater sea creatures that covered the majority of one wall. This affect may not be suitable or desirable by potential residents. There was no bed available in this room and the edge to the cover on the window sill was sharp at one side and the radiator beneath had areas of rust evident.

A maintenance system was described and arrangements were in place for the safe disposal of general and clinical waste. The relocation of the septic tank and some ground works had been undertaken since the last inspection. The inspector was told that the unfinished external grounds work was to be completed by spring 2016.

The centre was clean, suitably decorated and reasonably well-maintained. While the inspector was told that a timely response by maintenance was available to address issues identified and reported by the staff team, some matters were identified during inspection that required improvement which included:

- discoloured paintwork on the skirting boards and architrave following the action taken to address dampness and a water leak within the house foundations
- paintwork in parts that included the ceiling above the shower of the staff office ensuite was flaked and around light switches was stained
- the coating on the shelf at the bottom of the fridge was damaged and required assessment, maintenance or replacement to prevent infection
- the door of the dishwasher did not close easily and appeared strained

- an area where the shower surround/door connects with the shower tray in the first floor bathroom was discoloured and in need of attention to prevent infection or leak
- a malodour in the upstairs en suite/bathroom was evident
- some toilets were not fitted with a seat and/or a lid.

Occupied resident bedroom accommodation on the ground floor included one single occupancy bedroom with full ensuite shower facilities and one single occupancy bedroom with a communal bathroom that included a Jacuzzi bath. The floor covering and matters relating to the ground floor bathroom on the previous inspection had been addressed.

The first floor resident accommodation was also single occupancy and included two bedrooms with one shared bathroom that included a shower, wash hand basin and toilet.

A spacious kitchen, dining room and two separate sitting rooms were available on the ground floor and the utility room was located in the external building. A new table and set of chairs were in place that could facilitate up to eight persons and new sofas in the sitting room and in a resident bedroom was provide since the last inspection.

A small staff office was located on the ground floor and a larger staff office with an ensuite shower facility was available on the first floor.

An external courtyard, surrounding drive and gardens along with a separate building where activities for three residents were carried out was included in this premises facility.

There was an enclosed fenced area in the rear garden with hens and a rabbit that belonged to residents. Garden beds and vegetable patches had been re-located due to the required upgrading and relocation of the septic tank system and waste area which was cordoned off. Development and modifications to the gardens and the provision of a poly tunnel were proposed to be completed early next year.

Residents' bedrooms were personalised with photos and items of interest to them. Pictures of the resident group were displayed in many of the communal rooms and at communication boards and activity plans as a visual aid and schedule.

The premise had suitable heating, lighting and ventilation. The provision of thermometers was put in place following the last inspection to monitor room temperature. Temperatures were within normal ranges.

There were suitable space and storage facilities within the buildings for the personal use of residents. However, there was no external shed or shelter to protect personal items from the elements such as go-karts used by a resident on inspection.

Adequate car parking was available at the centre.

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):

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

Findings:

The inspector found that the requirements of the previous inspection were addressed; however, further improvements were required following this inspection.

Arrangements were introduced and under development to ensure that the health and safety of residents, visitors and staff was promoted. Improvements had been made since the last inspection that included changes in management and recruitment of staff to stabilize the workforce to enable a consistent approach to the care and support needed by residents.

While some training had recently taken place since the last inspection, mandatory training relevant to the resident profile was required by staff to ensure existing staff and the recently established and developing team had adequate knowledge, skills, supports and understanding of evidence-based practices to promote health and safety and to identify, manage and mitigate risks within the service.

There were corporate policies and procedures in place in relation to risk management and emergency responses. The centre had policies and procedures relating to health and safety. However, some improvement was required to ensure local arrangements were sufficiently reflected. Additionally, policy documents including the safety statement required review and updating.

Nine staff had attended an information session as training on infection control on 4 November 2015. Arrangements were in place and described for the prevention and control of infection. However, a policy in relation to the prevention and control of infection was not available on the policy files reviewed.

A risk management policy was available which included the matters set out in Regulation 26 including identification and management of risks, the measures in place to control identified risks and arrangements for identification, recording, investigation and learning from serious incidents. However, simulated drills in relation to missing person response had not been carried out despite being identified as a risk and training associated with the risk and management of violence and aggression had not been provided.

While a system of risk assessment and management reviews were in place, records of all risks had not been maintained or updated when reviewed to re-assess the risk following the implementation of controls measures and responses adopted.

A discrepancy in relation to the number of staff required to support individual residents when engaging in community activities was found during staff interviews and following a review of the risk assessment records available. As reported in outcome 5, deficiencies were found in relation to the detail contained in residents' personal care plans. Personal care plans for all activities requiring specific interventions, including the level of individual support needed, was not recorded to alleviate ambiguity and mitigate risk to residents and staff.

The number of adverse incidents relating to one resident that was of concern had reduced since the last inspection. The inspector met with a member of the multidisciplinary team who was visiting the centre to meet staff and review residents' behaviour. During the discussion, a 70% decrease in the episodes of behaviour that challenges relating to one resident was reported. However, the frequency in episodes in the form of self injurious behaviour remained similar. It was also confirmed that a multifunctional analysis for each resident was in the process of being completed that involved other professionals from various disciplines. This included speech and language therapy, occupational therapy, psychology, psychiatry and social work disciplines.

Arrangements for investigating and learning from serious incidents and adverse events involving residents were in place and described by the staff and management team. However, while systems had been introduced and developed to mitigate risks, further improvement was required based on the cumulative findings reported throughout this report.

The fire alarm system was serviced and maintained on a quarterly basis and fire safety equipment was serviced and maintained on an annual basis. Evacuation plans and a stocked emergency bag located in a central location near the front door formed part of the emergency procedures to be adopted.

There were adequate means of escape available, including emergency lighting and signage of fire exits. Fire exits were found to be unobstructed. However, each fire exit was operated by key lock and a key within a break glass unit to enable an emergency escape was not in place at each identified fire exit within the house or in the separate building where the utility and day area was used. The management told the inspector they would address this risk immediately.

There were prominently displayed signage and procedures for the safe evacuation from parts of the house. Fire drills were maintained that involved residents and staff. Simulated evacuations included evacuations to the external assemble point which was located near the entrance gate.

The inspector was informed that all staff were inducted with fire safety and safe evacuation procedures. Fire drills were conducted at regular intervals and fire records to include details of fire drills were maintained. However, based on discussions with staff and following a review of the training records available, the inspector was unable to find

evidence that all staff had received mandatory health and safety training or refresher training required in manual handling, fire safety, and non violent crisis intervention (NVC) posing a risk to residents who require their care and support and a risk occupational injury to staff which occurred previously. Training deficiencies is discussed further in outcome 17.

A control measure in a risk assessment reviewed included that all staff were to complete training on management of actual or potential aggression MAPPA/NVCI and training for staff in Multi Element Behaviour Support (MEBS) was referenced as required within the risk management policy. Evidence that this training had been completed for all staff was not found.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

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

Findings:

There was a corporate policy on, and procedures in place for, safeguarding residents, however, the policy was under review to reflect national guidance documents.

A record of attendance confirmed that some staff (nine) had recently attended training on safeguarding. At this time staff said they were informed that the organization's policy was under review to include elements of the Health Service Executive (HSE) national policy for safeguarding vulnerable adults.

Arrangements were described that involved the programme manager and person in charge in monitoring systems and arrangements in place to protect residents. The inspector confirmed with management that there were no incidents of harm or abuse between residents. Historically, incidents related to staff being targeted by residents and self-injurious behaviours.

Systems were described and outlined in policy documents to ensure any incidents, allegations or suspicions of abuse were recorded, investigated and responded to in line with the policy for the organisation. The inspector was informed that all safeguarding concerns are recorded as an adverse incident and reported to a dedicated liaison person (DLP) employed by the provider for assessment and response or investigation. This arrangement was confirmed in an examination of the incident records reviewed, however the outcome in relation to each safeguarding concern communicated to the DLP was not recorded on the adverse incident forms signed off following a review. The inspector was informed that the outcome was maintained separately elsewhere.

The inspector was told there were no active allegations, suspicions or reported abuse undergoing investigation and that the investigation ongoing at the last inspection had been completed within the past week. The programme manager agreed to notify HIQA of the outcome following this inspection. A record in relation to this matter was not available the centre. This is included in the action plan of outcome 18 for response.

Based on discussions with staff and following a review of the training records available, all staff had not completed training in relation to safeguarding and protecting residents. Management described that the staff training and development programme had recently commenced following the recruitment of staff to the core team and confirmed that all staff would receive training.

The policy in relation to providing personal intimate care was a corporate policy that included the requirement for all staff to attend one day training, however, based on the training records and following discussion with management at feedback this was not the policy or practice required for this centre. A policy is to be developed to reflect practices and arrangements for this centre.

There was a corporate policy in place for the provision of positive behavioural support and on the use of restrictive procedures and physical, chemical and environmental restraint. However, these combined policy documents contained up to 102 pages of narrative and did not sufficiently guide practice or describe the practices and procedures specific to this centre.

The policy included that all staff would be fully trained in managing behaviour that challenges including de-escalation and intervention techniques as required. However, based on the information available and from discussions with staff training, this had not been completed by all staff as outlined in the provider's previous action plan response.

While positive behaviour support plans were reviewed monthly by a committee that consisted of staff employed by the provider, they were not sufficiently detailed to describe the arrangements in place in relation to reactive strategies or interventions agreed and to be implemented as described by staff. MAPA techniques were used since the last inspection.

A number of staff including those recently employed told inspectors they had not previously worked in a social care setting. Training in positive behaviour support was provided by a member of the multidisciplinary team 4 November 2015 that nine staff had attended; however, not all staff had completed this training or training in non-

violent crisis intervention (NVCI) which was referenced in behaviour support plans for implementation.

The specifics in relation to physical, chemical and environmental restrictive practices and procedures were not clearly defined or described within a policy to ensure residents are sufficiently protected and safeguarded in accordance with national policy guidelines.

Procedures and arrangements in relation to the rights review committee and prescription of interventions was not sufficiently described or linked to the safeguarding, positive behaviour support or restrictive practice policies.

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):

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

Findings:

Arrangements were in place to ensure a record of all incidents occurring in the designated centre was maintained and, where required, arrangements were in place to notify the Chief Inspector.

The management staff demonstrated awareness of their legal responsibilities to notify the Chief Inspector. However, safeguarding suspicions documented in adverse incident reports as referred to designated liaison person (DLP) and the admission of a resident to hospital had not been notified to HIQA.

A report of the outcome into the investigation of an allegation of abuse by a staff member is to be forwarded to HIQA as requested.

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):

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

Findings:

There was a policy on access to education, training and development.

The inspector found that arrangements were in place to promote the general welfare and development needs of residents, however, further improvements were under development in order to afford residents new experiences, social participation, education, training and employment. Staff described plans recently initiated and being developed to advance the general welfare, development and occupation of residents.

Residents were being supported by staff to develop skills to engage in social activities, and to promote internal and external engagement. The inspector was informed that residents had not had the experience of a holiday or an overnight stay. Activities to develop the necessary skills and understanding to achieve such a goal were ongoing between residents, key-workers and the support team.

A programme of weekly activities was planned and recorded for each resident.

Judgment:

Substantially 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:

The inspector was told of arrangements that were in place to ensure that residents' healthcare needs were regularly reviewed with input from multidisciplinary professionals,

where required. Arrangements in relation to residents' access to the local GP, doctor-on-call and a range of allied healthcare services were available and facilitated.

A health assessment and monitoring document had been introduced since the last inspection which included checks of clinical observations, assessment of activities of daily living needs and abilities, and included treatment provided. However, on a review of resident healthcare records, gaps and incomplete records were found.

Health screening assessment documents were blank in many parts and in the absence of medical or psychiatric records available in the centre the inspector was unable to determine if suitable and sufficient arrangements were in place or available to residents as appropriate. For example, recorded information in relation to the screening and monitoring of a of periodic blood screening for a resident's prescribed and administered medication that required monitoring was not available or reflected in a related personal plan or assessment documents to demonstrate adequate and appropriate access to healthcare treatment was facilitated as required.

A dental record of one resident dated June 2014 included the requirement to have at least annual checkups, however, there were no further dental records and the health screening assessment was blank in this regard.

Another example included deficiencies in the monitoring of body weight, food and fluid consumption, or preferred and recommended diet for residents who were noted to be of concern. Overall the healthcare needs of residents were not sufficiently recorded or reflected in a related personal plan agreed by each resident.

On a review of the prescription kardex, the inspector noted that medical treatment prescribed by the GP on 4 November 2015 for 14 days was later omitted when the prescription kardex was re-written on the 6 November 2015 by another prescriber. Staff were unable to confirm the rationale for the omission and as a result returned the prescribed treatment to the pharmacy without establishing the facts. As a result of this, incomplete records and disconnect between the internal and external prescribers meant that the resident had not received the treatment as intended as referenced in outcome 12.

Menu planning formed part of the discussion between residents and staff in weekly meetings. Menu choices were displayed and photographs of food and meals choices were available to serve as a support aid for residents.

Residents were supported to buy, prepare and cook evening meals, while the planned meals on the menu displayed were varied, they were limited in relation to balanced healthy choices as many of the meals were fish, spaghetti bolognese, beef or lasagne accompanied by chips, rice or pasta. The provision of vegetables or salad options or sides was not included.

Other related areas for improvement were highlighted in above outcomes and within outcome 5. Staff training specific to nutrition and hydration had not been completed by all staff supporting residents. The inspector was informed that training by a speech and language therapist who worked within the organization was to facilitate staff training

following this inspection, however, the services of a dietician were not available in a timely manner to ensure residents' nutritional needs were met and monitored to an acceptable standard based on the information gathered and reviews undertaken in multidisciplinary meetings.

A corporate policy on monitoring and documentation of nutritional intake was available on file, however, it had not been sufficiently implemented in practice.

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):

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

Findings:

A medicines management policy was in place and matters raised on the last inspection were addressed. A system of returning medication was in place, a staff signature bank was available and relevant sections of the prescription kardex were completed to include known allergies. However, the inspector found that further medicines management and related practices required improvement.

Arrangements found that the rostering and availability of staff trained in safe administration of medication, along with the practices related to prescribing, review and administration recording of medication were not sufficiently suitable or appropriate and required improvement.

On review of the staff roster for the week of the inspection, the inspector found two staff rostered to work together for three consecutive nights that had not completed training in safe administration of medication to enable them to administer medication to residents as prescribed or as required. A review of residents' prescription kardexs confirmed that medication was required and prescribed for residents at night and on an as required basis (p.r.n.). The social care leader was informed of this finding and acted immediately to address this deficiency during the inspection.

In a review of adverse incident records since the previous inspection, the inspector noted a number of medication errors had occurred that included omissions and delays in the administration of medication.

Medication prescribed on an archived kardex was recorded as administered on a current record where the medication had not been prescribed/re-written.

As referenced in a previous outcome, a review of the prescription kardex showed that medication prescribed by the GP on 4 November 2015 twice daily for 14 days had not been included in the re-written kardex on the 6 November 2015. Staff were unable to explain the rationale for the omission and the prescribed treatment was returned to the pharmacy without establishing the facts. As a result of an absence of communication and breakdown in systems, and in the absence of clinical records maintained in the centre, the resident had not received the treatment as intended and initially prescribed.

The medication storage arrangements were found to be safe. A locked drug cupboard secured in the staff office was in place and a record of medication returned to the pharmacy was maintained.

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:

A statement of purpose was available that consisted of the aims and objectives of the designated centre and which contained most 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.

The inspector discussed the statement of purpose with the provider nominee, programme manager and social care leader on the first day of the inspection which resulted in subsequent amendments made. This included that the maximum number of residents to be accommodated was changed from four to five residents in line with the application to register.

However, the number of whole time equivalent staff available was considerably reduced. Based on the findings of inspection, the assessed and reported needs of residents and given the improvements required, the inspector informed management that an increase in resident numbers was not recommended at this time.

Confirmation of surname to be used by the PIC required clarification.

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):

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

Findings:

Governance structures, organisational procedures and reporting systems were in place.

The person in charge (PIC) was on planned leave to quarter two of 2016. HIQA had been notified of this absence.

The programme manager was deputizing in the PIC's absence with support from a residential coordinator and the social care leader.

The social care leader manages the service on a day-to-day basis with daily support of the residential coordinator. The team are supported with assistance from administration staff working within the wider organization in relation to training and management of staff allocation including agency staff for roster planning.

The statement of purpose outlined a management structure that included the person in charge reporting to the "Programme Manager" who reported to the "Regional Director" who reported to the Director of Services and to a board of management.

The management structure was arranged to ensure all decision makers were sufficiently engaged in the line management and involved in the governance of this centre.

A range of audits and review meetings were implemented on a weekly and monthly basis to discuss matters arising, identify risks, trends, determine outcomes and inform governance and management arrangements.

Staff and management meetings, and on call arrangements were described to support the assessed needs of residents. However, management arrangements were not consistently adequate and the on-call response had not been timely in relation an incident in August 2015. The inspector read an adverse incident of an assault of a staff member by a resident at 6pm which resulted in the staff member going off duty. The on-call supervisor and residential coordinator were informed. The remaining staff on duty were agency staff and the four residents did not receive their medication as prescribed between 8pm and 10pm until midnight when the on call supervisor arrived to the centre.

Management systems described as in place aimed to support residents and to promote the delivery of safe quality services. The social care leader, in conjunction with the management and staff team, implemented changes to bring about improved outcomes for residents. The social care leader demonstrated a good knowledge of residents and held a person-centred philosophy of residential care. Staff members were complimentary of the progress made to date in stabilizing the staff team and reported that staff morale had improved that had a positive effect on residents.

While improvements had been made in recent weeks, further improvement was required as reported throughout this report and in particular to inequitable rostering, inadequate supervision and allocation of staff, absence of training and dependency on agency staff due to core staff absenteeism.

Adequate supervision arrangements for all staff had not been maintained in accordance with the organisation's policy. The inspector read that a staff member's performance required further review in February 2014 following a review carried out in December 2013, however, there was no subsequent review undertaken or evident on file.

An annual review of the service is to be completed by January 2016. Monthly review meetings and a progress review based on the previous inspection outcomes and response was completed. This review included matters addressed and outstanding such as staff training deficits in many areas and as found on inspection.

Weekly reports for monitoring purposes were requested by inspectors following the last inspection in relation to staffing provision, residents' activity arrangements and incidents occurring within the centre. The management team were informed at feedback to continue the submission of weekly reports for monitoring which will be evaluated and reviewed in association with the action plan response.

The notification submitted to HIQA regarding the change in provider nominee indicated they were also a person participating in management. However, on inspection there was ambiguity expressed in this regard that was to be clarified by the provider.

The date of photographic identification for a board member had expired and confirmation in relation to the surname used by the person in charge was required.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The staff that facilitated the inspection were aware of the responsibility and requirement to notify the Chief Inspector of any proposed or unplanned absence of the person in charge.

The person in charge (PIC) was on leave until quarter two of 2016. HIQA had been notified of this planned absence.

The programme manager was deputising in the PIC's absence with support from a residential coordinator and the social care leader.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

The inspector was informed that sufficient resources were available to meet residents' assessed needs as required. However, to date the designated centre had not been sufficiently resourced to ensure the effective delivery of care and support which has been emphasised in other outcomes with non-compliances.

Based on the findings of this inspection and on the needs of the existing four residents who were supported by four staff and the social care leader daily, an increase in resident and staff numbers to the environment may challenge the arrangements with greater numbers or people, greater noise, stimuli and activity levels. Residents living in

the centre had sensitivity to noise and adaptation to crowded places. Previous and frequent changes in staffing personnel had negatively impacted on residents' behaviour which impacted on others within the centre. The application and intention to accommodate five residents required review and due consideration by the management and staff team in line with resources available, the statement of purpose and function of the centre and those already accommodated.

Core staffing levels had been outlined on a planned and actual roster to reflect the whole time equivalent numbers of staff resources. Vacancies and the lack of mandatory and relevant training suggested there was a lack of adequate resources to ensure effective delivery of care and support in accordance with the statement of purpose.

While deficiencies in core staffing resources were replaced with agency staff, the allocation of staff, skill mix and arrangement of a rolling roster did not ensure the best use of available resources. For example, two registered nurses were rostered to work together on nights while two care assistants were rostered on other nights to work together, as referenced in other outcomes.

The recruitment of up to three core staff and the transfer of a staff member from another service operated by the provider had brought about staff improvements since the last inspection. However staff vacancies up to four and a half whole time equivalent (175.5 hours) staff resources weekly continued to be required from a relief panel or by agency providers. Additionally, staff training and the necessary resources required to facilitate staff training had not been determined and required improvement. This is reported in the action plan for outcome 17.

The centre had two private vehicles on a full-time basis to support residents' transportation needs and wishes. The inspector was told by some staff working in the centre that they had yet to be indemnified to drive the vehicles.

Judgment:
Non Compliant - Moderate

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:

Overall the staffing arrangements and levels of core staff had improved since the last inspection. However, the registered provider had not ensured that the number, qualifications and skill mix of staff were appropriate to the number and assessed needs of the residents at all times.

The inspector was informed by staff and management of vacant staff posts as a result of staff being on long term leave and transfer arrangements.

The provision of the staffing numbers and provision of staff whole time equivalent (WTE is 39 hours) and skill mix outlined in the statement of purpose and function was dependent on agency and relief staff.

Staffing provision within the centre had been heavily reliant on a panel of on-call relief staff that was co-ordinated from a central allocations office; this included staff members working in other centres operated by the registered provider in addition to the use of agency personnel.

The review of the rosters showed that a female member of staff was not consistently rostered to work and support a female resident, despite the inspector being told by staff that the female resident preferred female staff support. This preference had also been communicated by the resident's parent to staff.

There was evidence of negative outcomes for residents due to insufficient and inconsistent staffing arrangements which had been highlighted previously and in other outcomes throughout this report. For example, inappropriate staff responses following adverse incidents, delayed on-call arrangements and errors, delays, discontinued and omissions in medication.

Based on the assessed needs of residents, the social care leader and four staff were required daily with two (wakening) staff at night. Review of workforce planning and allocation of staff based on their training, experience and skills was required. The social care leader with the support of administration staff had maintained a planned and actual roster. However, changes were required during the inspection in the arrangements planned for the week of the inspection to address deficiencies noted by the inspector; such as, two care staff unable to administer medication to residents were rostered to work nights (12 hour periods) as referenced in outcome 12. On the same week's roster two registered nurses were rostered to work together on nights. The inspector found that three members of the core staff compliment had completed safe administration of medication training and the competency assessment to enable them to support residents. Therefore, the centre was heavily reliant on external and agency staff to meet the assessed needs of residents' medication administration.

The person in charge had not ensured that all staff working in the centre had access to appropriate training, including refresher training, as part of a continuous professional development and recruitment programme.

The inspector was informed by management and staff that training had been cancelled and deferred due to staff shortages. Following the recent recruitment of staff the core staff team had increased to approximately 66%. Training had been initiated in some areas within the previous week; however, all staff working in the centre had not completed all relevant and necessary training to support the assessed needs of residents and as stated in the response to the previous report and areas highlighted and discussed throughout this report.

While there was no policy on staff training and development as required in schedule 5, the inspector read in other policy documents that all staff were to be trained in positive behaviour support and management/multi-element behaviour support, NVC/management of actual or potential aggression (MAPA), safeguarding and intimate care. However, all staff had not completed this training.

The inspector read in adverse incidents records since the last inspection (August 2015) that staff left the building during episodes of aggressive and challenging behaviour of one resident. This practice was confirmed by managers. This response did not demonstrate that staff were appropriately or sufficiently trained or equipped to respond to the assessed needs of residents.

Training specific to the resident's profile, assessed needs and emergency response including first aid and basic life support had not been facilitated for all staff who were supporting residents with behaviour that challenges, aggression, self harm and who had conditions such as epilepsy.

Training specific to nutrition and hydration, weight management, social integration, person-centred planning, communication, autism, consent, assessment and management of skin integrity and dysphagia was also required based on the findings of this inspection in order to suitably equip staff for their roles and responsibilities to adequately support residents and care for their assessed needs.

Administration staff employed by the provider/organisation maintained staff files in relation to the information and documents specified in Schedule 2. The inspector reviewed a sample of staff files and found that in the main documents required were available, however, gaps in staff training and supervision arrangements along with the absence of declarations of Garda Síochána vetting were found.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

The inspector found that arrangements in place to maintain records required improvement to ensure complete and accurate records were maintained and available, as outlined in previous outcomes.

A copy of insurance cover for the centre was made available and current.

A resident's guide was available in an easy-to-read and illustrative format that provided detail in relation to the service.

A copy of all correspondence to or from the designated centre relating to each resident was not available. The inspector found that hard copy records related to residents and staff were stored securely and made available on request, however, some correspondence and electronic records were not available. Problems from a lack of Internet connectivity were described as a barrier to accessing records. While other records such as investigations of safeguarding matters and complaints that the HSE were involved in were not available or maintained in the centre in accordance with the regulations.

Staff were aware of the requirements in relation to the retention of records, however, a policy to reflect regulatory requirements was not found in the centre.

A hardcopy record of the directory of residents was available, however, it had not been completed to meet the requirements of the regulations to include transfers and hospital admission and return dates. The inspector was informed that this information was maintained on a shared folder; however, this was not available as there was no Internet access in the centre at this time.

The centre had some of the written operational policies required and specified in schedule 5 and a small number of local procedural policies. However, many were generic and corporate policies required review to reflect practices and arrangements

described and approved for practice related to this centre.

A number of the policy documents had not been reviewed as required at intervals not exceeding three years and, where necessary, updated in accordance with best practice.

While some local protocols had been implemented in September 2015, other policy documents were dated 2009. The inspector was informed that a committee had been set up to review policies.

Based on inspection findings the following policies were in need of improvement or some were not available:

- the admission, transition and discharge criteria was not transparent to reflect actual procedures and arrangements
- the policy for providing personal intimate care was to be developed to reflect practices
- procedures and arrangements for the provision of information to residents was not available
- the policy in relation to visiting arrangements was not available
- the safeguarding policy was under review to include national policy
- the specifics in relation to physical, chemical and environmental restrictive practices and procedures were not clearly defined or described within the related policy to ensure residents were sufficiently protected and safeguarded in accordance with national policy guidelines
- procedures and arrangements for infection control were not reflected in the risk management or health and safety policies available
- staff training arrangements, including the frequency of mandatory training such as manual handling, fire safety and adult safeguarding and other recognised or specific training identified in policy documents and reported in previous outcomes such as positive behaviour support and management, multi-element behaviour support, MAPA, social integration, person centred planning and first aid along with other relevant training required to support residents such as food safety and hand hygiene was not detailed in a staff training and development policy
- the medicines management policy did not reflect all procedures and arrangements required to be in place to support residents when on leave from the centre or out on an activity with one member of staff and medication as required (p.r.n.) to be administered
- the creation of, access to and retention of, maintenance of and destruction of records.

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:

Sonia McCague
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002967
Date of Inspection:	10 November 2015
Date of response:	7 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:

Further development of staff was required to ensure the centre is operated in a manner that respects resident's gender, intimate care needs, disability, family status, right to advocacy and consent.

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

1. Action Required:

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

A review of the roster will take place to ensure that there is a gender balance across the roster so far as possible within the current complement.

Proposed Timescale: 29/02/2016

Theme: Individualised Supports and Care

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

Gaps were found in documents available to demonstrate residents were consistently involved in decisions about their care and about the organisation of the centre.

Arrangements and engagement with family and other professionals involved in the care and welfare of residents was lacking and not sufficiently maintained in the centre.

2. Action Required:

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

Documentation will be completed accurately to demonstrate the resident's involvement in decisions about their care. 29th February 2016

A family contact sheet will be introduced to ensure all correspondence with families are documented and maintained in the designated centre. 18th December 2015

Proposed Timescale: 29/02/2016

Theme: Individualised Supports and Care

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

The preference of female staff to support a female resident was not provided consistently.

3. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

A review of the roster will take place to ensure that there is a gender balance across the roster so far as possible within the current complement.

Proposed Timescale: 29/02/2016

Theme: Individualised Supports and Care

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

Arrangements in relation to transactions or deductions from resident's bank account/s was not managed by, known or accessible to staff working in the centre.

4. 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:

All residents have an individual financial passport in their personal plan, this details all their deductions paid on a weekly basis. All staff have access to this and will familiarise themselves with same.

Proposed Timescale: 31/01/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Internet access was not available during the inspection. This deficiency was reported by staff as a recurrent problem that had been previously escalated to management and that required immediate attention.

5. Action Required:

Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

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

The contract for our Wide Area Network is up and is being put out to tender for an improved service with additional services for consistent and improved connectivity for the designated centre. 30th May 2016

In the interim, a wifi solution that connects with the organisations server will be put in place until the new system is put in place. 31st January 2016

Proposed Timescale: 30/05/2016

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:

Defining and understanding the determining factors for the exclusion criteria outlined such as those with high medical needs was unclear to all staff. Therefore, the policy and procedures lacked transparency as required.

6. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

The exclusion criteria will be revised specific to the designated centre and will be communicated to all staff at a team meeting.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

Residents did not have an agreed written contract/terms which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident and the fees to be charged.

7. 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:

Residents will have an agreed and signed contract of care in place and kept in their personal plan.

Proposed Timescale: 29/01/2016

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:

The records available were incomplete and did not demonstrate that a comprehensive assessment or review had been maintained to identify needs, abilities and changes to inform a personal plan to ensure the arrangements and interventions were put in place to meet the assessed needs of residents and aid evaluation.

Resident's communication needs were not sufficiently identified in the health assessment template to inform an assessment and the personal planning process.

8. 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:

Residents communication needs are detailed in their communication passport and critical information sheet. A reference to these documents will be added to the residents health assessment.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

While assessment documents were signed off and in use in practice they were incomplete in many sections that resulted in a breakdown in communication and disconnect in the transfer of specific information that included the input of internal or external appointments and assessment recommendations, and where necessary the requirement of a referral or follow up.

9. 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:

All assessments will be completed. 30th April 2016

Keyworkers will communicate residents appointments at weekly team meetings and these will be put into the communication book & diary as per the residents health action plan. 31st January 2016

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

Records containing concerns raised by multi disciplinary professionals in meetings held in the previous months in relation to one residents weight gain and recommendations to access a dietician had not been appropriately acted upon or completed to ensure appropriate assessment, monitoring and development of a specific personal plan.

10. 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:

A referral will be made to the community dietician through the GP for this resident.

Proposed Timescale: 29/02/2016

Theme: Effective Services

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

Arrangements to consult and involve family members or representatives, where appropriate, in the review of plans was not consistently recorded to confirm or illustrate arrangements.

11. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

A family contact sheet will be introduced to ensure all correspondence with families is documented and maintained in the designated centre.

Proposed Timescale: 18/12/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Matters identified regarding the premises during inspection that required improvement which included:

- discoloured paintwork on the skirting boards and architrave following the action taken to address dampness and a water leak within the house foundations
- paintwork in parts that included the ceiling above the shower of the staff office ensuite was flaked and around light switches was stained
- the coating on the shelf at the bottom of the fridge was damaged and required assessment, maintenance or replacement to prevent infection
- the door of the dishwasher did not close easily and appeared strained
- an area where the shower surround/door connects with the shower tray in the first floor bathroom was discoloured and in need of attention to prevent infection or leak
- a malodour in the upstairs ensuite/bathroom was evident
- some toilets were not fitted with a seat and/or a lid
- the edge of the cover on the window sill in the vacant room was sharp at one side and the radiator beneath had areas of rust evident
- unfinished external grounds work was to be completed by spring 2016
- there was no external shed or shelter to protect personal items kept outside from the elements such as go-karts used by a resident

12. Action Required:

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

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

A schedule of maintenance will be developed. 31st January 2016

All the issues above will be addressed. 30th September 2016

Proposed Timescale: 30/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Mandatory and training relevant to the resident profile had not been provided to promote health and safety and to identify, manage and mitigate risks within the service.

The inspector read in adverse incidents records since the last inspection that staff left the building during episodes of aggressive and challenging behaviour of one resident. This practice and response did not demonstrate that staff were appropriately equipped or sufficient emergency response arrangements were in place.

Simulated drills in relation to missing person response had not been carried out despite being identified as a risk and training associated with the risk and management of violence and aggression had not been provided.

A record of all risks had not been maintained or updated when reviewed to re-assess the risk following the implementation of controls measures and responses adopted.

13. Action Required:

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

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

1. All staff will be MAPA trained. 31st March 2016
2. A missing person drill will be carried out. 30th April 2016
3. The residents risk assessments, the risk register and the risk management policy are reviewed monthly against the Adverse incident reports to ensure a record of all risks are identified and control measures re-rated if required.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

Fire exits operated by key lock did not have a key within a break glass unit located close by to enable an emergency escape.

14. 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:

Break glass units will be installed at each fire exit.

Proposed Timescale: 31/12/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

All staff were not trained in managing behaviour that is challenging including de-escalation and intervention techniques as required.

15. Action Required:

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

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

All staff will be MAPA trained.

Proposed Timescale: 31/03/2016

Theme: Safe Services

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

Adverse incidents records included that staff left the building during episodes of aggressive and challenging behaviour of one resident. This practice and response did not demonstrate that staff had appropriate skills or were appropriately equipped to respond to behaviours that challenged.

16. Action Required:

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

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

Staff are inducted into residents positive behaviour support plans with proactive and reactive strategies. Staff are supported and encouraged to follow same. All staff will be MAPA trained.

Proposed Timescale: 31/03/2016

Theme: Safe Services

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

All staff had not completed training in relation to safeguarding and protecting residents.

17. 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:

All staff currently on leave and not currently working in the designated centre will receive fresher training in safeguarding before returning to work.

Proposed Timescale: 30/06/2016

Theme: Safe Services

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

The intimate care policy included the requirement for all staff to attend one day training, however, this was not provided.

18. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

The Organisational policy on intimate care is currently being reviewed and revised by a review committee for presentation to the CEO for their consideration and approval.

Proposed Timescale: 30/06/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Safeguarding suspicions documented in adverse incident reports and referred to DLP had not been notified to the authority.

19. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

Going forward all safeguarding suspicions for this designated person reported to the DLP will be notified to the Authority.

Proposed Timescale: 07/12/2015

Theme: Safe Services

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

The admission of a resident to hospital had not been notified to the authority.

20. Action Required:

Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

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

All Serious Injuries will be reported to the Authority by completion of an NF03 form. All minor injuries will be included on Quarterly notifications.

Proposed Timescale: 13/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

On a review of resident health care records gaps and incomplete records were found.

21. 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:

Residents health care records will be reviewed to ensure all records are completed.

Proposed Timescale: 30/04/2016

Theme: Health and Development

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

Where medical treatment was recommended such treatment was not facilitated as required

22. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

All medical treatment and interventions recommended for the residents will be facilitated.

Proposed Timescale: 29/02/2016

Theme: Health and Development

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

When a resident required services provided by dietician, access to such services was not provided by the registered provider or by arrangement with the Executive.

When a resident required services provided by a dentist following a recommendation to have annual check-ups was not provided.

Healthcare needs of residents were not sufficiently recorded or identified in assessment documents or reflected in personal plans to ensure residents are supported to access appropriate care and information.

23. Action Required:

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

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

A referral will be made to the community dietician for the resident that requires support.

A follow up appointment will be made for the resident to attend the dentist.

Residents health care records will be reviewed to ensure all records are completed.

Proposed Timescale: 30/04/2016

Theme: Health and Development

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

Meal plans were limited in relation to balanced and healthy choices that met individual needs.

24. Action Required:

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

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

Residents are offered healthy meal options however the residents select meals of their choice at weekly house meetings using pictorial cues.

Proposed Timescale: 07/12/2015

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:

A number of medication errors had occurred that included omissions and delays in the administration of medication was found.

Staff had been rostered to work together for three consecutive nights that had not completed training in safe administration of medication to enable them to administer medication to residents as prescribed and/or as required.

Medication prescribed on an archived kardex was recorded as administered on a current record where the medication had not been prescribed/re-written.

25. 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:

All medication errors have been reported through the medication variance procedure and investigated.

Staff trained in the administration of medication will be available to administer medication as prescribed to the residents at all times.

Proposed Timescale: 14/12/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The number of whole time equivalent staff available was considerably reduced in the most recent statement of purpose.

Based on the findings of inspection, assessed and reported needs of residents and given the improvements required the inspector informed management that an increase in resident numbers was not recommended at this time.

Confirmation of surname to be used by the PIC required clarification.

26. Action Required:

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

The statement of purpose has been reviewed and the number of whole time equivalent staff revised and has been forwarded to the Authority. 15th November 2015

On stabilisation of the designated centre, the registered provider will review the statement of purpose, the function of the centre, the number of residents that the centre can accommodate and the resources required to ensure the assessed needs of the residents are met. 31st May 2016

The PIC's marriage certificate will be forwarded to the Authority. 30th January 2015

Proposed Timescale: 31/05/2016

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 date of photographic identification for one board member had expired.

The notification submitted to the Authority regarding the change in provider nominee indicated they were also a person participating in management. However, on inspection there was ambiguity expressed in this regard that was to be clarified by the provider.

27. Action Required:

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

Updated photographic identification will be forwarded to the Authority. 29th February 2016

The Authority will be notified to withdraw the Provider Nominees PPIM documents for this designated centre. 31st January 2016

Proposed Timescale: 29/02/2016

Theme: Leadership, Governance and Management

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

Confirmation in relation to the surname used by the person in charge was required.

28. Action Required:

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

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

The PIC's marriage certificate will be forwarded to the Authority.

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:

Management arrangements were not consistently adequate and the on call response had not been timely in relation an incident in August 2015.

An adverse incident of an assault of a staff member by a resident at 6pm which resulted in the staff member going off duty. The on call supervisor and residential coordinator were informed. The remaining staff on duty were agency staff and the four residents did not receive their medication as prescribed between 8pm and 10pm until midnight when the on call supervisor arrived to the centre.

While improvements had been made in recent weeks, further improvement was required as reported throughout this report and in particular to inequitable rostering, inadequate supervision and allocation of staff, absence of training and dependency on agency staff due to core staff absenteeism.

29. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

A review of the on call response to the incident in August will be ensure that appropriate arrangements are in place. 30th April 2016

Gaps in training will be identified and a schedule compiled for this training. 29th February 2016

Recruitment and allocation of staff to the designated centre is on-going.

Proposed Timescale: 30/04/2016

Theme: Leadership, Governance and Management

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

Adequate supervision arrangements for all staff had not been maintained in accordance with the organisations policy.

The inspector read that a staff members performance required review in February 2014 following a review carried out in December 2013, however, there was no subsequent review undertaken or evident on file.

30. Action Required:

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

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

A schedule of supervision and personal development reviews will be compiled by the Social Care Leader.

Proposed Timescale: 31/01/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

The designated centre had not been sufficiently resourced to ensure the effective delivery of care and support which has been emphasised in other outcomes non compliances.

Based on the findings of this inspection and on the needs of the existing four residents who were supported by four staff and the social care leader daily, an increase in resident and staff numbers to the environment may challenge the arrangements with greater numbers or people, greater noise, stimuli and activity levels.

Residents living in the centre had sensitivity to noise and adaptation to crowded places. Previous and frequent changes in staffing personnel had negatively impacted on resident's behaviour which impacted on others within the centre.

The application and intention to accommodate five residents required review and due consideration by the management and staff team in line with resources available, the statement of purpose and function of the centre and those already accommodated.

31. Action Required:

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

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

Recruitment and allocation of staff to the designated centre is on-going.

On stabilisation of the designated centre, the registered provider will review the statement of purpose, the function of the centre, the number of residents that the centre can accommodate and the resources required to ensure the assessed needs of the residents are met.

Proposed Timescale: 31/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The registered provider had not ensured that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents at all times.

A review of the workforce planning and allocation of staff based on their training, experience and skills was required.

Training had been cancelled and deferred due to staff shortages.

32. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

A review of the workforce and allocation of staff will take place for this designated centre to ensure the skill mix is appropriate to the assessed needs of the residents.

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:

Gaps in staff training and supervision arrangements along with the absence of declarations of garda clearance were found.

33. Action Required:

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

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

Gaps in training will be identified and a schedule compiled for this training. 29th February 2016

Garda clearance declarations will be followed up for the staff identified. 5th January 2016

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:

The person in charge had not ensured that all staff working in the centre had access to appropriate training, including refresher training, as part of a continuous professional development and recruitment programme.

All staff working in the centre had not completed all relevant and necessary training to support the assessed needs of residents.

Training specific to the resident profile, assessed needs and emergency response including first aid and basic life support had not facilitated for all staff who were supporting residents with behaviours that challenge, aggression, self harm and who had conditions such as epilepsy.

Training specific to behaviours that challenge, nutrition and hydration, weight management, social integration, person centred planning, communication, autism, consent, assessment and management of skin integrity and dysphagia was also required based on the findings of this inspection in order to suitably equip staff for their roles and responsibilities to adequately support residents and care for their assessed needs.

34. 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 schedule for all mandatory training will be compiled. 29th February 2016

Information sessions on topics pertaining to the residents assessed needs will be rolled out at team meetings. 30th September 2016

Proposed Timescale: 30/09/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

Based on inspection findings the following policies were not available or in need of improvement:

- the admission, transition/discharge criteria was not transparent to reflect procedures and arrangements
- the policy for providing personal intimate care was to be developed to reflect practices
- procedures and arrangements for the provision of information to residents was not available
- the policy in relation to visiting arrangements was not available
- the safeguarding policy was under review to include national policy
- the specifics in relation to physical, chemical and environmental restrictive practices and procedures were not clearly defined or described within the related policy to ensure residents were sufficiently protected and safeguarded in accordance with national policy guidelines
- procedures and arrangements for infection control were not reflected in the risk management or health and safety policies available
- staff training arrangements to include the frequency of mandatory training such as manual handling, fire safety and adult safeguarding and other recognised or specific training identified in policy documents reported in previous outcomes such as positive behaviour support and management, multi-element behaviour support, MAPA, social integration, person centred planning and first aid along with other relevant training required to support residents such as food safety and hand hygiene was not detailed in a staff training and development policy
- the medication management policy did not reflect all procedures and arrangements to be in place to support residents when on leave from the centre or out on an activity with one member of staff and medication was required (PRN) to be administered
- the creation of, access to and retention of, maintenance of and destruction of record

35. Action Required:

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

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

All policies raised above will be reviewed through the Policies, Procedures and Protocols Committee and locally in the designated centre to consider issues raised.

Proposed Timescale: 30/11/2016

Theme: Use of Information

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

A number of the policy documents had not been reviewed as required at intervals not exceeding 3 years and, where necessary, and updated in accordance with best practice.

The requirement to make available and complete Schedule 5 policies was reported following the previous inspection

36. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The review of organisational documents is outside the remit of the Registered Provider, therefore the regional Policy Procedure and Protocol Committee will review the policies that have exceeded the 3 year review period, taking the policies in Schedule 5 as a priority.

Proposed Timescale: 31/12/2016

Theme: Use of Information

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

A complete directory of residents was not available on inspection to include the information specified in paragraph (3) of Schedule 3.

37. Action Required:

Under Regulation 19 (2) you are required to: Make the directory of residents available to the chief inspector when requested.

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

A hard and soft copy of the up to date Directory of residents will be kept in the designated centre at all times.

Proposed Timescale: 31/12/2015

Theme: Use of Information

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

Improvements were required in relation to the maintenance and availability of records in the centre.

A copy of all correspondence to or from the designated centre relating to each resident was not available.

Medical assessments, treatment, care or reviews undertaken, and prescription changes and decisions made were not kept in the centre.

The outcome in relation to each safeguarding concern recorded on the adverse incident forms as communicated to the DLP was not available and had been signed off as reviewed.

A safeguarding investigation ongoing since the last inspection was reported as been completed within the past week. A record in relation to this matter was not available in centre. The programme manager agreed to notify the Authority of the outcome following this inspection.

38. Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

An improved system will be put in place to ensure that all records including electronic records are available in the Designated centre. 31st January 2016

Screening outcome sheets from all safeguarding concerns will be kept in the residents personal plan. 31st December 2015

The outcome of the recently completed safeguarding investigation will be forwarded to the Authority by the Programme Manager. 10th December 2015

Proposed Timescale: 31/01/2016