Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Hollybank
Centre ID:	OSV-0001921
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Peamount Healthcare
Provider Nominee:	Kevin McNamee
Lead inspector:	Anna Doyle
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
15 June 2016 09:30	15 June 2016 21:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the second inspection of this designated centre. At the last inspection the centre had been part of a larger designated centre. However, due to a reconfiguration of the larger centre, the provider had submitted an application to register this centre as a standalone centre. The purpose of this inspection was to follow up on actions from the previous inspection carried out in the larger designated centre in June 2014 and to monitor on-going compliance with the regulations.

Description of the Service

This centre is operated by Peamount Healthcare and is situated on a campus based setting in County Dublin. It comprises of a large unit that can accommodate 25 residents. The unit is primarily divided into two areas and provides care to both female and male residents with intellectual disabilities; who require additional supports in areas such as, mobility issues, behaviours that challenge and dementia care.

In addition the centre also provides short-term respite to residents from other areas of the campus with increased short-term medical needs. One bedroom in the centre was used for palliative care for residents who may require this support; both from

the campus and from other centre's on the campus. 24 hour nursing support is provided in the centre.

How we gathered evidence
Over the course of this inspection, inspectors met all of the residents living in the centre with the exception of one resident. Inspectors spoke to four of the residents informally. They expressed that they were happy living in the centre. Some of the residents were unable to express their views on the quality of services in the centre but inspectors observed mealtimes, reviewed personal plans and observed interactions between staff and residents. The person in charge had been newly appointed since the last inspection and was interviewed at this inspection. In addition two staff were met formally and documents were reviewed including risk assessments, staff rotas and financial records. A senior nurse manager met with inspectors during the inspection to discuss the actions from the last inspection carried out in the centre.

Overall judgment of our findings
Inspectors found that a number of the actions from the last inspection had not been implemented to a satisfactory level as outlined in the body of this report. In particular, one major non-compliance relating to the reconfiguration of the premises that was due for completion in December 2015 had not been completed. Overall inspectors found that while staff presented as very caring and residents looked well cared for, insufficient staffing levels in the centre were contributing to negative outcomes for residents.

Significant failings were found over all of the outcomes inspected against and significant improvements were required in order to meet the requirements of the regulations. Major non-compliances were found in seven of the ten outcomes inspected and moderate non-compliances were found in the other three outcomes. In response to three of the findings the provider was asked to submit further information to HIQA as to how these issues would be addressed. Only some of this information had been submitted at the time of this report. The action plan at the end of this report addresses the improvements required.

The provider attended a meeting in HIQA's Dublin office prior to the publication of this report to discuss the findings of this inspection and provide reassurances to HIQA that the actions identified would be implemented.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Overall inspectors found that the actions from the previous inspection had not been fully implemented and improvements were required in relation to resident's finances and upholding residents' rights in the centre.

Not all aspects of this outcome were reviewed at this inspection. Inspectors found that the residents finance policy had been reviewed since the last inspection and that residents had a contract of care in place. This had been an action from the last inspection.

However, some aspects of the finance policy were in conflict to the information contained in the contracts of care. For example the policy stated that the provider would supply equipment/ aids as appropriate to care while the contract of care stated that equipment/aids were supplied under the medical card scheme. In addition some of the information contained in the policy was not respecting residents' rights. For example it stated in the policy that requests from family members to withdraw funds from residents' monies for their own personal use should be made to the assistant director of health and social care. This was not respecting residents' rights.

Inspectors viewed one resident's financial records and found that the systems in place may not adequately safeguard residents' finances. For example one record showed where they may have been a misappropriation of residents' funds as the balance of monies on the records viewed were incorrect for one transaction viewed by inspectors. This was discussed at the feedback meeting.

In addition two residents financial statements viewed showed that residents were charged a significant amount for one service provided in the centre. This could not be clarified on the day of the inspection as the finance office was closed. The provider was asked to submit confirmation of fees to HIQA the day after the inspection.

This information was submitted; however inspectors found that the fees charged were not the fees recorded on the two residents' financial statements viewed at the inspection. Inspectors asked for additional information from the provider to address this matter. At the time of this report not all of the information had been submitted.

Staff were observed to treat residents with dignity and respect. However, inspectors found that some practices were not sensitive in order to promote a residents right to privacy and dignity. For example information relating to residents' communication needs was written on a white board on a corridor in the centre.

Judgment:
Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Overall inspectors found that residents had a written agreement in place. However, improvements were required in admissions to the centre and the admissions policy.

Residents had a written agreement in place. However, they were not signed by the resident or a representative where appropriate. In addition the agreements did not include the fees to be charged, details of additional charges and it did not fully outline the services to be provided.

There was no admission policy in place in the centre. This was discussed at the feedback meeting and inspectors were informed that the service had a policy not to accept new referrals from external services and therefore did not have a service policy on admissions to the centre. Inspectors were informed that a flow chart process for transfers between services was in operation instead of an admission policy, in order to guide practice. Inspectors asked for this to be submitted to HIQA for review.

The information submitted included a transfer/transition policy from residential care. On review inspectors found that most of the information contained in this policy related to residents who were transitioning from a campus based setting to a community based setting within services. The process for residents transferring between designated centres in the campus was presented on a transition flow chart and was not detailed enough to guide practice.

In addition inspectors found that this process was not effectively implemented into practice. For example inspectors viewed minutes of meetings where the transition of some residents were discussed and found that the minutes did not include transparent criteria for admission to the centre. There were no transition plans in place and the process of admission did not include the wishes, needs and the safety of other residents in the centre. This was discussed at the feedback meeting.

Respite services were also provided in the centre and inspectors found that this practice was not respecting other residents' rights in the centre. For example, there were no allocated bedrooms for respite services and residents admitted were sharing rooms with other residents that lived in the centre. This had been done without any consultation with the resident who lived in the centre.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Overall inspectors found that the actions from the previous inspection had not been fully implemented and significant improvements were required in a number of areas.

The actions from the last inspection included the implementation of a comprehensive assessment of need and a monitoring system to review personal plans. Inspectors found that from viewing a sample of plans that for the most part these actions had not been

fully implemented.

For example while each resident had an assessment of need in place, it did not include the changing needs of residents and all their healthcare needs. In addition a separate assessment of need for social care goals called ' a meaningful day assessment' had not been reviewed since 2013.

Inspectors found that residents had access to some activities in the centre. For example music therapy, pet therapy and art therapy occurred in the centre once a week and aromatherapy sessions occurred twice a week. Residents had access to a sensory room, however on the day of the inspection no residents were seen to avail of this with staff.

Residents could also avail of day services on a session basis on the campus and inspectors observed residents availing of this on the day of the inspection. However, inspectors found that access to the local community or activities outside of the campus were limited for residents.

One resident's activity record was reviewed and found that over an 18 day period, the resident had gone for a drive once. In addition access to the bus was limited to approximately once a month for all residents. Inspectors were informed by the provider that further buses were being purchased to address this issue.

Multidisciplinary annual reviews were being completed for residents that included family representation. However inspectors found that the minutes kept were poorly documented and included no clear action plans.

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):
No actions were required from the previous inspection.

Findings:
Overall inspectors found that the layout and design of the centre was not suitable to meet residents' collective needs in a comfortable and homely way.

At the last inspection significant failings were found premises, in relation to the dining experience for residents in the centre. This had been actioned under Outcome 11 at the last inspection. In response, the provider had undertaken to have major renovation works to the centre in order to comply with the regulations, however to date this had not been completed.

This was discussed at the feedback meeting and inspectors were informed that the original tender process was in excess of the allocated budget secured for the works to be completed. The provider informed the inspector that the tender process was to begin again and that a decision would be finalised in two months at which time the provider would inform HIQA of a start date for works to be completed in the centre.

Inspectors found that shower/bathing facilities for residents were adequately maintained, however equipment was being stored there, and had to be removed when residents required personal care. In addition other areas of the centre had broken equipment stored that was no longer in use.

There were three outside areas where residents could sit. However, inspectors found that this was not adequately maintained. For example some areas needed to be cleaned.

Some bedrooms were personalised, however, others were not. Inspectors were informed that this was due to residents' bedrooms being redecorated. One resident's bedroom had inadequate storage facilities and inspectors were informed that this was because there was insufficient room and the wardrobe had to be removed.

In addition there were multi occupancy rooms, one being a four bedroom room. Inspectors acknowledge that there were practices in place to protect resident's dignity in these rooms. For example curtains were available around the beds in order to provide privacy. Inspectors were also informed that the new reconfiguration of the centre would address this issue. However, double occupancy rooms would still be in place.

Inspectors were not satisfied that the communal areas in the centre were adequate to meet the needs of all residents. For example one area where a resident liked to spend quiet time as they did not like noise levels was located on a corridor through which other residents and staff accessed other parts of the centre.

There was a kitchen in the centre that was clean and well maintained however, there were no cooking facilities available in the centre.

There were systems in place for the management of clinical waste and domestic waste in the centre.

Assistive equipment was available to residents in the centre; however, the storage of this equipment was not adequate. Maintenance records were stored in the maintenance department. A sample were viewed and found to be satisfactory.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Overall inspectors found that there were health and safety systems in place. However, three of the four actions from the previous inspection had not been fully implemented and improvements were still required in these areas. In addition improvements were required in infection control procedures and risk registers in the centre.

Inspectors reviewed the action plan identified under health and safety from the last inspection and found that there was now a risk management policy in place in the centre that contained the risks specified in regulation 26. A fire consultants report had also been completed for the centre and smoking risk assessments were in place for residents who smoked. In addition staff spoken to were familiar with the evacuation procedures in place. These actions therefore had been fully implemented.

However, other actions had not been fully implemented to a satisfactory level under this outcome. Inspectors found that staff had not received training in risk assessments and some staff had not completed appropriate fire training. Personal evacuation procedures were now in place for residents, however, they were not detailed enough to guide practice. In addition inspectors found that while there was now a system in place to review incidents in the centre, the review did not include the identification of trends so as to inform learning and guide future practice that was specific to the designated centre.

The centre had an infection control policy in place, however inspectors were not satisfied that the practices, procedures and standards in place for the management of one healthcare associated infection were in line with best practice guidelines on the day of the inspection. For example there were no risk assessments or support plans in place. In addition medical charts and personal plans viewed did not provide sufficient information in order to guide staff. This was discussed at the feedback meeting.

Assurances were sought from the provider after the inspection as to how they intended to address this issue. Subsequent to this a policy was submitted to HIQA from the provider along with an e-mail from a medical practitioner that provided assurances that the provider was mitigating risks in the centre. However, the policy submitted did not include any details of what arrangements were in place to protect other residents living

in the centre or guidance on the required control measures in order to mitigate risks, for future residents being admitted to the centre given that the centre provided respite and palliative care.

Inspectors reviewed certification to show that fire equipment, fire alarm and emergency lighting were all serviced by an external company. There was adequate means of escape, however on the day of inspection, inspectors observed a fire exit blocked by hoist equipment. This was removed by staff. The centre had completed a fire drill in the last year which did not record the time but identified issues and actions to resolve them.

The centre maintained a risk register which included risks in the centre and noted which residents were subject to risk. However, the register did not identify all risks present. For example, there was no risk assessments in place on, wandering and the risk assessments on malnutrition and choking did not identify all residents at risk of this.

However, inspectors did observe practices in place that mitigated these risks. For example all residents had clear guides/plans during meal times on the potential risks and dietary requirements. Residents who were at risk of wandering had monitors in place to alert staff if they left the building. This was activated a number of times during the inspection and staff were observed to respond in a timely manner.

There were household staff in place and inspectors reviewed a sample of cleaning checklists and schedules. There was personal protective equipment, hand wash gels and facilities located throughout the centre.

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:
Overall, inspectors found that there were measures in place to protect residents from suffering harm or abuse. However, improvements were required in behaviour support

plans, restrictive practices and intimate care plans. In addition one of the actions from the last inspection had been completed and one had only been partially completed.

Inspectors were informed that one of the actions had been completed, in that one resident had transitioned to more suitable living accommodation since the last inspection. The other action related to the establishment of a human rights/restrictive practice committee to review all restrictive practices. Inspectors were informed that this had been established but was not active and therefore restrictive practices were not being reviewed by this committee as yet.

The centre had a policy on the prevention, detection and response to abuse. Inspectors observed staff treating residents with respect and warmth. Inspectors spoke to staff and found they were knowledgeable on what to do in the event of an allegation of abuse and were familiar with the designated officer in the centre. However, inspectors found that not all staff had completed safeguarding training.

The centre had a policy place for the provision of behavioural support. Inspectors reviewed a sample of behaviour support plans and found that they did not adequately guide staff. Staff informed inspectors of an intervention implemented in response to one resident's behaviour and this intervention was not included in the behaviour support plan.

Inspectors also found two versions of a behaviour support plan in one residents file, therefore staff may not be consistent in implementing the behaviour support plans. In addition the reactive strategies in place for one resident did not guide practice. This was discussed at the feedback meeting.

There was a restraint policy in place in the centre. The centre had identified one restrictive practice and records showed that alternative measures had been trailed and it had been reviewed by a multi-disciplinary team. However, inspectors identified other restrictive practices in use in the centre, for example falls monitors, bed rails and a wandering alert system. It was not evident on the day of inspection that these interventions were regularly reviewed and monitored as restrictive practices and they were not notified as such to HIQA.

There was no intimate care plans in place to guide personal care so as to ensure that residents dignity was maintained. Inspectors were informed that the service was in the process of implementing a new policy on intimate care that would address this issue.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Overall inspectors found that the action from the previous inspection had not been fully implemented and improvements were required to ensure health care needs were met so as to ensure that the care provided was safe and in line with best practice.

Since the last inspection improvements to the dining experience had been implemented. Residents now had access to a range of snacks for the evening time and during the day. Specific dietary requirements had been assessed and there were guidelines in place where appropriate. Inspectors observed how residents were offered choices for meals. However the dining areas in the centre had not been reconfigured in the centre and therefore the actions from the previous inspection had not been fully implemented. This has already been outlined in this report.

A sample of residents' personal plans were viewed and inspectors found that residents had access to a general practitioner and allied health professionals where appropriate. However the review from allied health professionals was not always reflected in the residents care plan and had not been followed up on. For example one recommendation from a dietician had not been addressed.

Health action plans were not in place for some residents healthcare needs. For example residents with dementia had no health action plans in place around the supports required. In addition the assessment tool used to inform this diagnosis was not in line with best practice guidelines and had no input from relevant allied health professionals.

Inspectors were not assured the care provided was consistently, monitored effectively and in line with best practice. For example residents who had end of life plans in place that contained 'do not resuscitate order' had little documentary evidence to support best practice was been adhered to. This was discussed at the feedback meeting and the provider was subsequently asked to provide assurances to HIQA as to how this would be addressed. The information submitted found that a multi disciplinary meeting had been held to discuss the issues, however further improvements were required.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Overall inspectors found the actions from the last inspection relevant to this area were implemented, however significant improvements were required in the medication policy and medication practices in the centre.

The medication policy made available to inspectors on the day of the inspection related to medication practices in a community setting and did not reflect the services provided on the campus. In response to this the provider was asked to submit the medication management policy for the centre to review the guidance on the handling and disposal of unused and out of date medicines, including controlled drugs.

The information submitted comprised of a table of contents of the medication procedures in place. It was indicated on this document that some procedures were under review. This included procedures on administration of medication via feeding tube, ordering medication and stock management and medication reconciliation. Therefore inspectors found that not all procedures on medication practices were available in the centre.

Medications were supplied from an external pharmacy in the community and emergency supplies could be accessed from the pharmacy on site. Medications were stored in a locked trolley. However additional medications that were stored in the treatment room were not secured.

There was a temperature controlled fridge in place for medications that required refrigeration. However inspectors found that staff did not know, what one medication stored in the medication fridge was for as there were no residents prescribed this in the centre. Controlled drugs were stored in the centre and there was a system in place where staff checked medications twice as a day. However, controlled medications no longer prescribed were still being stored in the centre.

Inspectors reviewed a sample of medication administration sheets and prescription sheets and found a number of discrepancies. This included:
-No maximum dose was recorded on the prescription sheets for three as required (PRN) medications
-PRN protocols were not in line with what was written on the prescription sheet.
-There were no indications for use on some medications prescribed. For example one resident was prescribed a medication for behaviours that challenge.
-There was a section in place on the prescription sheet for when medications were

withheld. Inspectors saw where one residents medication had been withheld, however there was no adequate explanation for this medication being withheld.

There were no residents self medicating in the centre.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
Overall inspectors found that while there were defined management structures in place, improvements were required in order to monitor and develop the quality of care for residents living in the centre.

Since the last inspection a new person in charge had been appointed in the centre. They had taken up the role at the beginning of June 2016. The person in charge was a registered nurse for intellectual disabilities. They were interviewed at the inspection and found to be knowledgeable of the residents' needs and had a knowledge of their responsibilities under the regulations.

The person in charge had 24 hours protected time every week in order to carry out administration work. However, since taking up the role this could not be facilitated due to staff shortages. This was discussed at the feedback meeting.

A clinical nurse manager 2 (CNM2) had been recently appointed to the unit four days ago to support the person in charge in their role. They were present throughout the inspection and were responsive to any issues raised.

There were clear reporting structures in place. The person in charge reported to the assistant director of nursing and the interim director of services who in turn reported to the provider nominee. Weekly managers meetings were held that the person in charge attended. However, there were no scheduled meeting for the person in charge to meet with their direct line manager to discuss issues involving the care and support of

residents in the designated centre.

An unannounced review of the quality and safety of care in the centre had not taken place and there had been no annual review for the designated centre since the last inspection.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Overall inspectors found that since the last inspection the actions from the previous inspection had not been fully implemented. The actions related to staff supervision and inadequate staffing levels in the centre.

Inspectors found that since the last inspection the staffing levels in the centre had been increased, however inspectors were not satisfied that the staffing levels were adequate to meet the assessed needs of residents. Inspectors spoke to staff who were knowledgeable about the needs of residents, however all staff spoken to felt that there were insufficient staff available to meet residents social care needs.

Inspectors observed staff to be very busy on the day of the inspection and there were little activities taking place with residents who remained in the centre during the day. This was discussed at the feedback meeting and inspectors were informed that a staffing review had taken in place in the centre earlier in the year, the findings of which had been implemented. The staffing compliment was now eight staff on duty all day. Inspectors asked for a copy of this review to be submitted to HIQA following the inspection.

This was submitted and on reading this inspectors found that the assessment was based on three areas of activities of daily living. The activities of daily living were basic needs including personal care, support at mealtimes and dressing. Residents other support needs were not included in this review, for example behaviours that challenge, dementia

and social care needs. The total time for the provision of these services as outlined in the review amounted to almost 89 hours or the equivalent of 7.5 whole time equivalents in a twelve hour period. In addition medication management practices required additional hours that were not included in the 89 hours.

Inspectors reviewed rosters and found that there were days when insufficient staffing levels were in place in order to meet residents' basic needs. Some days the centre had only seven staff rostered on duty. Inspectors also found that there was an over reliance on agency staff in the centre due to sick leave and annual leave. Inspectors acknowledge that the provider was taking measures to address this by recruiting a relief panel for the centre.

Inspectors were informed that relevant senior staff were now trained in the supervision of staff. The person in charge informed inspectors that they had facilitated supervision for one staff in the centre and that they planned to roll this out to all staff.

Mandatory training records were reviewed and inspectors found significant gaps in the records. For example staff had not attended safeguarding vulnerable adults, fire safety and manual handling. No other training records were reviewed at this inspection.

Staff files were not reviewed as part of this inspection.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Hollybank
Centre ID:	OSV-0001921
Date of Inspection:	15 June 2016
Date of response:	14 July 2016

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:
Some practices in the centre did not uphold resident's rights' to privacy.

Information contained in the finance policy was not upholding residents' rights.

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

Please state the actions you have taken or are planning to take:
1. Practice promotes residents' right to privacy. The white board on a corridor has been cleared of all personal information. All information pertinent to service users is now only available to view in personal care/ support plans and secure files. Completed

2. The policy on the management of service users' monies is in final draft and amended to address the anomaly between the contract of care and the finance policy in regard to the supply of aids and appliances and respecting residents' right in regard to withdrawals of monies for personal use. 31 August 2016

Proposed Timescale: 31/08/2016

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The finance policy did not guide practice in the centre.

One financial discrepancy was noted on one residents' records.

The fees charged to residents for one service provided in the centre, was not reflected in the residents financial statements.

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

Please state the actions you have taken or are planning to take:
1. The revised policy on the management of service users monies is being amended to uphold the individuals' rights and to clearly guide and improve practice. Complete

2. The financial discrepancies as noted on the day of inspection in an individual's record and financial statement has been reviewed. The finding was that the individuals ledger was incorrectly debited rather that credited. Complete

3. The learning from this investigation informed the review of the policy on the management of service users' monies. Complete

Proposed Timescale: 07/09/2016

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:
The provision of respite services and new admissions in the centre, did not take account of other residents wishes or safety and did not respect residents rights to privacy.

3. Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
1. The admission policy will be reviewed to reflect the residents' privacy, wishes and safety. 30 September 2016
2. There is a designated respite room. Completed
3. The Statement of Purpose has been amended to include the consultation process for the use of a respite service. Completed

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' transition plans did not contain a transparent criteria for admission to the centre

There was no admission policy in place in the centre as required under the regulations.

4. 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:
1. An admission policy will be developed, outlining the admission criteria, the discharge from one designated centre and admission to another designated centre in accordance with the statement of purpose. 30 September 2016

2. Transition plans will be developed for each resident transferring from one designated centre to another to include the wishes, needs and the safety of other residents in the centre. Ongoing

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Written agreements were not signed by the resident or their representative where appropriate.

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

Please state the actions you have taken or are planning to take:
The resident or their representative will be contacted to sign and agree the revised Contracts for Care.

Proposed Timescale: 30/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Written agreements did not include the fees to be charged, details of additional charges and it did not fully outline the services to be provided.

6. 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:
1. The Contract of Care will be amended to include the support, care and welfare of the resident, and details of the services to be provided, and the fees to be charged. 30 September 2016
2. This revised contract will be discussed with each individual resident and/or their representative and signed with their agreement. 30 November 2016

Proposed Timescale: 30/11/2016

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 assessment of need did not include changing needs of residents and all healthcare needs.

The assessment of need for social care needs had not been updated since 2013.

7. 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:
A comprehensive assessment of residents' healthcare and social care needs will be completed for all residents and will be reviewed regularly to capture changing needs. 1 December 2016 and ongoing

Proposed Timescale: 01/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents social care needs were not being met in the centre.

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

Please state the actions you have taken or are planning to take:
1. A comprehensive assessment of residents' social care needs will be completed for all residents. 1 December 2016
2. Plans will be put in place to address any assessed needs and these will be implemented. Ongoing

Proposed Timescale: 01/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The minutes from residents' annual reviews had no action plans identified from the review.

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:
1. All annual reviews will be reviewed to ensure that action plans are in place for any changes in circumstances and new developments. 30 September 2016
2. A system will be put in place to ensure that future plans have corresponding action plans, when the need arises. 30 September and ongoing

Proposed Timescale:

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Areas of the centre did not meet the requirements set out in Schedule 6 of the regulations including inadequate storage facilities for one resident; inadequate/ unsuitable communal areas for residents and no cooking facilities were available in the centre.

10. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
1. Plans for revised layout to address storage, communal seating areas and cooking facilities and the revised costing have been completed for the unit. Completed
2. Given the level of cost involved to complete this project Board approval is required. A proposal for the works and the expenditure involved is being brought to next board meeting scheduled for the 14th September.
3. Following approval for the expenditure and the works by the Board the budget costs and timeframe for completion will be submitted to HIQA. 30 September 2016

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The layout and design of the centre were not suitable to meet residents' collective needs in a comfortable and homely way.

11. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
1. The planned revised layout and revised costing have been completed for the Centre, to ensure that the revised layout and design are suitable to meet residents' collective needs in a comfortable and homely way. Complete
2. Given the level of cost involved to complete this project Board approval is required. A proposal for the works and the expenditure involved is being brought to next board meeting scheduled for the 14th September.
3. Following approval for the expenditure and the works by the Board the budget costs and timeframe for completion will be submitted to HIQA. 30 September 2016

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Outside seating areas for residents were not maintained.

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:
1. External seating area has been cleaned and maintained. Complete
2. New furniture has been ordered and will be put in place. 8 September 2016

Proposed Timescale: 08/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
Not all risks had been identified on the risk register.

There was no process in place to identify trends specific to the centre so to inform learning and guide future practice.

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. The Person in Charge and the risk management coordinator have reviewed and updated the risk register. All risks are now up to date on the register. Complete

2. Trends for each centre are compiled monthly and forwarded with recommendations to the Person in Charge for discussion at staff meetings. Ongoing

Proposed Timescale: 07/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The practices, procedures and standards were not in place in the centre for the management of one healthcare associated infection.

The infection control policy on the management of the healthcare associated infection did not guide practice.

There were no risk assessments or support plans in place to guide practice in the management of one healthcare associated infection.

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

Please state the actions you have taken or are planning to take:
1. Risk assessments have been completed on each service user identified with a healthcare associated infection. Completed
2. The risk register has been reviewed and updated to reflect control measures in place to prevent the transmission of a healthcare associated infection. Completed
3. Care plans have been completed on service users with a healthcare associated infection. Completed
4. The communicable disease record in section A of the personal plan has been completed to include details of any healthcare associated infection. Completed
5. The infection prevention and control guidelines including standard and transmission based precautions, Standard Operational Procedure on blood glucose monitoring and prevention of healthcare acquired infection will be communicated to all staff to guide practice. 1 November 2016
6. The process of the communication of communicable disease between GPs, Unit staff and Infection Prevention and Control Team will be outlined in a policy to be communicated to all staff. 1 November 2016

Proposed Timescale: 01/11/2016

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
The records for a fire drill that had taken place in the centre, did not include details of the times of the evacuation.

Personal evacuation plans were not detailed enough to guide practice.

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

Please state the actions you have taken or are planning to take:
1. Individual evacuation plans have been completed for each service user. Completed
2. Photos and instructions are on display in event of a fire at the two main exits. Completed
3. A fire drill was carried out and the times of evacuation were recorded. Completed

Proposed Timescale:

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date appropriate fire training.

Staff had not completed risk assessment training as outlined in the last inspection carried out in the centre.

16. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
1. Risk assessment training for staff has commenced and will be complete for all staff. 31 October 2016
2. All staff have completed training in fire safety and the use of fire equipment. Completed

Proposed Timescale: 31/10/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The is failing to comply with a regulatory requirement in the following respect:
Inspectors identified restrictive practices in use which were not recorded and reviewed.

17. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
1. All restricted practices are being recorded on the restraint register which is incorporated into the weekly monitoring form, which is reviewed by the Person in Charge and Person Participating in Management, in line with the national policy and evidence based practice. Ongoing
2. All restrictive practices will be notified to HIQA. Ongoing

Proposed Timescale: 07/09/2016

Theme: Safe Services

The is failing to comply with a regulatory requirement in the following respect:
Behaviour Support Plans did not adequately guide staff.

One personal plan had two behaviour support plans in place.

One practice used was not recorded on the residents behaviour support plan.

18. 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:
1. The personal plan that had two positive behavioural support plans in place has been reviewed and now contains one (correct) positive behavioural support plan. Completed
2. The positive behavioural support plan that did not have one practice used recorded on it has been reviewed and this issue has been addressed. Completed
3. All positive behavioural support plans have been reviewed by the Clinical Nurse Specialist in Behaviours of Concern to ensure that they adequately guide staff. Completed
4. All staff will receive training in positive behavioural support. 31 December 2016

Proposed Timescale: 31/12/2016

Theme: Safe Services

The is failing to comply with a regulatory requirement in the following respect:
Intimate care plans were not in place.

19. 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:
1. Intimate care policy is now in place outlining best practice in the provision of intimate care. Completed
2. Intimate care plans are in place for each service user. Completed

Proposed Timescale: 07/09/2016

Theme: Safe Services

The is failing to comply with a regulatory requirement in the following respect:
Not all staff had received safeguarding training.

20. 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 have now completed safeguarding training. Completed

Proposed Timescale: 07/09/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
End of life plans were not maintained in line with best practice.

21. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
1. End of life plans will be reviewed to include DNR status in consultation with the service user and / or representative, the multidisciplinary team and the GP with clinical governance for the individuals' health needs. Complete

2. End of life plans will be reviewed annually or more frequently where there is a change in circumstances. Ongoing

Proposed Timescale: 07/09/2016

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no health action plans in place for some residents assessed needs.

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

Please state the actions you have taken or are planning to take:
1. There are dementia specific care plans for all residents
2. New admissions to the centre will have health action plans completed following application of the findings from the use of a revised, validated Multi-Disciplinary Team assessment tool (dementia specific). 31 October 2016 and ongoing

Proposed Timescale: 31/10/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A recommendation from an allied health professional was not reflected in the residents personal plan had not been followed up on.

The assessment tool used to inform a diagnosis for one resident was not in line with best practice guidelines and had no input from relevant allied health professionals.

23. 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:
1. A validated Multi-Disciplinary Team assessment tool will be completed for individuals requiring dementia screening.

2. A comprehensive assessment of need will be sourced and utilised in the centre to ensure that changing needs of residents are captured.

3. All recommendations from allied health professionals will be incorporated into each resident's personal plan.

4. A monitoring system will be put in place to regularly review personal plans.

Proposed Timescale: 31/10/2016 and ongoing

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:
Some procedures on medication management were not in place in the centre.

24. Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
The medication management policy will be reviewed by the existing medication management committee and changes approved through the Drugs and Therapeutics committee.

The revised policy will be communicated to the staff via the Person in Charge as part of ongoing education.

Proposed Timescale: 30/09/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Controlled drugs no longer prescribed were still stored in the centre.

One medication stored in the refrigerator was no prescribed for any resident in the centre.

Additional medications stored in the treatment room were not locked away.

25. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
1. Unused controlled drugs have been returned to pharmacy in line with policy. Completed and ongoing
2. Medication in refrigerator has been disposed of in accordance with policy and fridge will be checked weekly. Completed and ongoing
3. Locked doors have been placed on the treatment room where additional medication has been stored. Completed and ongoing

Proposed Timescale: 07/09/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A sample of prescription sheets and administration sheets found that:
- No maximum dose was recorded on the prescription sheets for three as required (PRN) medications
-PRN protocols were not in line with what was written on the prescription sheet.
-There were no indications for use on some medications prescribed. For example one resident was prescribed a medication for behaviours that challenge.
-There was a section in place on the prescription sheet fro when medications was withheld. Inspectors saw where one residents medication had been withheld, however there was no adequate explanation for this medication being withheld.

26. 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:
1. The Person in Charge has spoken to the GPs to address:
a) the absence of maximum dose being stated on prescription sheet for three PRN medications - Complete
b) that there were no indications for use on some medications prescribed. 30 September 2016
2. Prescription sheets have been reviewed and amended by the GPs. Complete
3. The Person in Charge and the Clinical Nurse Manager will monitor medication charts monthly to ensure: - 30 September 2016 and ongoing
• PRN protocols are in line with the prescription sheet

• All PRN prescriptions have a maximum dose stated on the prescriptions sheets
• All PRN medications have clearly stated indications for their use
• Adequate explanations are detailed in any instance where medication is withheld.

Proposed Timescale: 30/09/2016

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 person in charge's protected time was not always available to them so as to ensure oversight over the quality and care of services in the centre

27. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
The Person in Charge is supported by a Clinical Nurse Manager 2 and a Nursing structure. This will facilitate protected time to ensure oversight of quality of care and services. Completed and ongoing

The level of protected time is dictated by service need and will be kept under stringent monthly review between the Person in Charge and their line manager to ensure that the Person in Charge has sufficient protected time to ensure oversight of quality of care and Services. Completed and ongoing

Proposed Timescale: 07/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no meetings held between the person in charge and their line manager in the centre to discuss the quality and care of services.

28. 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:
Monthly Supervision meetings will be held between the Person in Charge and their Line Manager, to provide support and supervision to the Person in Charge. The quality and care of services will be discussed at these meetings. 5 October 2016 and ongoing

Proposed Timescale: 05/10/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An unannounced review of the quality and safety of care in the centre had not taken place.

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

Please state the actions you have taken or are planning to take:
The registered provider will ensure that unannounced reviews of quality and safety will take place on a six-monthly basis. 30 September 2016 and ongoing

Proposed Timescale: 30/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No annual review had been completed for the designated centre since the last inspection.

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

Please state the actions you have taken or are planning to take:
An annual review of quality and safety of care will be completed.

Proposed Timescale: 16/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient staff available in order to meet the assessed needs of residents.

31. 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 third party (independent external) review of staffing structures, levels and skill mix will be commissioned.

Proposed Timescale: 31/10/2016

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an over reliance of agency staff in the centre.

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

Please state the actions you have taken or are planning to take:
1. A relief panel of regular staff is being recruited to provide continuity of care and support during annual leave and sick leave periods, and to reduce the reliance on agency staff. Ongoing

2. The Person in Charge will ensure that agency staff currently being used are familiar with the service users, to ensure continuity of care and support. 15 September 2016 and ongoing

Proposed Timescale: 15/09/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff were not trained in safeguarding vulnerable adults and fire safety.

Staff were not receiving supervision in the centre.

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

Please state the actions you have taken or are planning to take:
1. The staff who had not completed Safeguarding and Fire Safety training have now received this. This training will be scheduled for any new staff. Completed and ongoing.
2. Person in charge will provide ongoing one:one supervision in line with the supervision policy. 30 September 2016 and ongoing

Proposed Timescale: 30/09/2016