

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Cork Association For Autism
<b>Centre ID:</b>	OSV-0002113
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Cork Association For Autism
<b>Provider Nominee:</b>	Nola MacPhie
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Louisa Power
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	13
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was unannounced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
04 May 2016 09:00	04 May 2016 16:00
09 May 2016 09:00	09 May 2016 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 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 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This unannounced inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 21 and 22 October 2015.

The centre provides a service specifically for adults with autism. The centre is set in five acres of land outside a village in a picturesque and calm environment. The centre comprises a main house and seven cottages and can accommodate 13 residents. As part of the inspection, inspectors met the person in charge, whose dual role was also that of provider nominee, the director of services, staff and inspectors visited and met residents in their homes.

Overall, residents were provided with a person-centred individualized service. Staff were observed to interact with residents in a positive and appropriate manner. Staff demonstrated an understanding of how to support residents to manage their own

behaviours that may challenge in a respectful way that maximised residents' choice and personal independence.

At the previous inspection, an immediate action plan was issued in relation to staffing arrangements. Inspectors found that the immediate action plan had been implemented. In addition, significant improvement had been made to reduce incidents of behaviours that may challenge.

However, a number of major non-compliances were identified or remained at this inspection: Under Outcome 5: Social Care Needs, the assessment of residents' needs was not comprehensive and the person in charge/provider nominee was requested to arrange for such an assessment to be completed without delay for individual residents with complex healthcare or behaviour support needs. Under Outcome 6: Safe and Suitable Premises, one part of the designated centre was not designed or laid out to meet residents' mobility needs. Under Outcome 11: Healthcare Needs, the person in charge/provider nominee was required to take immediate action to clarify individualized protocols in place as they related to epilepsy management. Under Outcome 12: Medicines Management, unsafe medicines management practices were observed in relation to homeopathic and 'as required' medicines.

Other non-compliances were identified including in relation to the follow-through of recommendations from a multidisciplinary team and the provision of staff training. In addition, the management structure required review to ensure that the roles of the provider and person in charge could be fulfilled in accordance with the regulations.

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

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

One aspect of this outcome was included due to findings identified on inspection in relation to consent.

Inspectors found that the practices around consent in relation to social and healthcare interventions was not in line with national guidance applicable to community and residential settings, such as the national consent policy 2014 published by the Health Service Executive (HSE). For example, parents provided consent for some residents in relation to the provision of healthcare and administration of medicines.

**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):**

No actions were required from the previous inspection.

**Findings:**

Overall, staff were observed to support residents to communicate choices and preferences. Improvement was required to ensure that input from Multidisciplinary Team (MDT) in relation to supporting residents to communicate were implemented in full. At the previous inspection it was found that a resident who had communication difficulties was not always supported by appropriately trained staff.

Since the previous inspection, training had been provided to new staff in relation to autism and positive behaviour support, that included supporting residents' communication needs. The director of services was experienced and qualified in this field.

Input had been provided from a multidisciplinary team in relation to communication supports for some (four) residents. For other residents, behaviour support input had been provided that considered how residents may be communicating their wishes and needs. However, the follow-through of MDT recommendations required review as not all recommendations were being implemented. For example, where recommendations had been made by a specialist behavioural support team in relation to supporting residents to communicate pain, these recommendations were not being followed by staff.

Residents' files contained comprehensive information to ensure that staff supported residents to communicate in a predictable and consistent environment, including communication passports and communication dictionaries. Inspectors observed that staff supported residents to communicate their wishes and preferences. Visual schedules, daily planners and a picture exchange communication system (PECS) were visibly displayed and observed to be used by staff. Some staff used LAMH (an Irish manual sign system) to support communications, where applicable.

**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:**

At the previous inspection, it was found that the registered provider had failed to agree in writing on admission, 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. Written contracts of care were not in place for each resident that outlined the services to be provided and the fees to be charged.

Since the previous inspection, the Director of Services and person in charge had progressed this action and had communicated with families in relation to same. However, contracts of care had yet to be developed and none were in place at the time of this inspection. As such, this action has yet to be completed in full.

**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):**

No actions were required from the previous inspection.

**Findings:**

Overall, residents' social care needs were met by staff and each resident had a personal plan. Issues relating to incompatibility of residents living together identified on the previous inspection had improved. However, the review of the personal plan was not multidisciplinary. In addition, a major non-compliance was identified in relation to the comprehensive assessment of residents' needs and the suitability of the designated centre to meet the needs of all residents.

An assessment of residents' health, social care and developmental needs was in place for residents. However, this was not always comprehensive and the assessment of residents' needs had not been carried out by an appropriate healthcare professional. Inspectors identified residents with complex behaviour support or healthcare needs who required more comprehensive assessment. As a result, the supports required to meet residents' needs were not clear, for example, in relation to MDT or nursing supports. The person in charge was requested to arrange for a comprehensive assessment to be completed for all residents in the centre, and for such assessments to be completed for

individual residents with complex needs as soon as possible.

As identified on the previous inspection, each resident had a personal plan. Personal plans were individualised. Input of residents and family involvement was evidenced. Personal plans outlined residents' likes and dislikes, who is important in their lives, how to support residents to communicate, positive behaviour support strategies and interventions, activities, day services and personal goals. However, the review of the personal plan was not multi-disciplinary, as required by the Regulations.

Information in relation to resident's individual health care needs was included in personal plans. However, the information contained in all plans seen would not adequately guide staff to support residents in relation to managing their health care needs. In addition, plans had not been developed in relation to all resident's health care needs including constipation, dermatitis, fungal infections, eczema, regurgitation and mental health.

Issues relating to incompatibility of residents living together were identified on the previous inspection. The person in charge had taken steps to improve this situation. In one premises, this involved a 'reintroduction plan', whereby residents were being supported to positively re-engage with each other. In another premises, multi-disciplinary and behaviour support had been sought and there had been changes to the staff team, staff training and staff supervision. Inspectors found that the two situations identified on the previous inspection had stabilised. The person in charge and staff members told inspectors that the measures taken were working well. This was evidenced by a reduction in incidents between residents. The available communal space in one premises to support on-going positive relationships by offering sufficient space for individuals to go to be alone remained an issue and this will be discussed under Outcome 6: Safe and suitable premises.

However, it was not demonstrated that the designated centre met the needs of all residents. Where residents had mobility and healthcare needs, it was not demonstrated that the skill mix of staff or the design and layout of the premises met residents' needs. This is further discussed under outcomes 6, 11 and 17.

**Judgment:**  
Non Compliant - Major

**Outcome 06: Safe and suitable premises**

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

**Theme:**  
Effective Services



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

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

**Findings:**

Inspectors found that overall, the premises was homely, comfortable and individualised. Non-compliances were identified in relation to two premises within the designated centre in terms of the design and layout of parts of the centre and available communal space.

At the previous inspection it was found that not all areas in the designated centre were designed and laid out to meet the aims and objectives of the service and the number and needs of residents. There was limited communal space in one shared premises. Two residents shared a single open-plan kitchen/dining/living space. As a result, residents had no place to go to be alone other than their bedrooms. This was previously identified as not being adequate to meet resident's individual behaviour support needs. The provider's action plan following the previous inspection was for a second living area in the shared premises. This was to be completed by 30 April 2016. However, an unforeseen planning issue had delayed this work and as a result, the action has yet to be completed.

As previously discussed under Outcome 5: Social Care Needs, inspectors found that the design and layout of one premises did not meet individual resident's mobility needs. This had also been identified by the Director of Services, who had brought it to the attention of the HSE. Issues identified by the Director of Services included rising damp, the narrow corridor and narrow doors that resulted in difficulty opening doors when a wheelchair was being used. In addition, the narrow corridor meant that staff could not use the a resident's 'handling belt' in accordance with manual handling instructions as there was insufficient space for a staff member to stand on each side of the resident (as was required in terms of correct and safe support of the resident when mobilizing).

**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:**

Improvement had been made in relation to non-compliances identified at the previous inspection. Further areas for improvement related to risk assessments, personal emergency evacuation plans, management of medication related incidents and infection control.

At the previous inspection, it was identified that not all hazards had been identified and not all risks had been assessed. Since the previous inspection, the property manager had completed a 4-day external health and safety training course and a date was scheduled for an external consultancy to carry out a health and safety risk assessment. The Director of Services and person in charge confirmed that an updated manual handling assessment for a resident was scheduled for completion by a physiotherapist.

Individual risk assessments were available in residents files and they related to individual risks, such as absconding, self-injurious behaviour, behaviour that may challenge (including during transport) and burns or scalds. However, risk assessments viewed were outside of their review date and referenced staff who no longer worked in the centre. In this way, it was not clearly demonstrated how the effectiveness of control measures were reviewed and informed staff practices or supports provided to residents.

Servicing records were within their review date for emergency lighting, fire alarms and fire equipment. Staff participated in regular fire drills. According to training records, seven staff required initial fire safety training. In addition, personal emergency evacuation plans required review. A sample plan reviewed for a resident with mobility needs did not outline how that resident would be evacuated in the event of a fire.

An inspector reviewed a sample of medication related incident forms and saw that incidents were identified, recorded and investigated. Immediate remedial actions were implemented. However, inspectors noted there was a lack of a systems based approach to medication safety. For example, the learning from a recent medication error relating to paracetamol had not been implemented across the centre.

At the previous inspection, non-compliances were identified in relation to the general cleanliness of the premises and the infection control policy. At this inspection, the standard of cleanliness was satisfactory. The person in charge told inspectors that two staff were trained hand hygiene assessors and staff were also observed to support residents to wash their hands. Infection control advice had been sought in relation to the prevention and control of healthcare associated infections from a HSE community infection control nurse. However, training records indicated that the majority of staff had not received infection control training, as required for the prevention and control of healthcare associated infections. Cleaning schedules were in place. Staff were provided with personal protective equipment where required (such as gloves). An infection control policy had been introduced since the previous inspection. The policy referenced that the organisation follows the HSE South Cork and Kerry Guidelines on Infection Control (Community and Disability Services) 2012. The policy required further development to reflect the service's own practices in relation to infection control, for example in relation to staff training, hand hygiene assessment and how/when to access infection control advice.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

Overall, a positive approach to behaviour support was demonstrated by staff. Behaviour support plans were required for some residents and training gaps were also noted.

At the previous inspection, peer to peer incidents were highlighted. A review of incident forms and discussion with staff indicated that there had not been any incidents since January 2016. This was previously discussed under Outcome 5: Social Care Needs.

Staff were observed to interact with residents in a positive and appropriate manner. Staff demonstrated an understanding of how to support residents to manage their own behaviours that may challenge in a respectful way that maximised residents' independence.

New staff had commenced in the centre since December 2015. While the majority of new staff had received training in the safeguarding of vulnerable adults and positive behaviour support, training records indicated that not all staff had received this training. For example, four staff required training in the safeguarding of vulnerable adults. Staff with whom inspectors spoke were however clear in relation to the importance of reporting any suspicions, incidents or allegations of abuse.

Inspectors reviewed a sample of behaviour support plans. External input had been sought for some plans and others were developed by an in-house registered behaviour analyst. Overall, the majority of behaviour support plans reviewed were comprehensive and demonstrated a positive approach to behaviour that may challenge. However, some inconsistencies were noted as one plan reviewed only contained reactive strategies and did not outline antecedents or possible or known triggers or proactive strategies. In addition, some residents who required behaviour support plans had different protocols in place, but not a behaviour support plan. This had also been identified as a gap by the person in charge/provider nominee in their annual report in October 2015.

Where the reason underlying the behaviour was unclear, recording and monitoring in the form of weekly behaviour charts, behaviour motivation assessments, mood charts and incident forms were completed and analysed by the behaviour analyst. However, where there were on-going behaviours of concern, MDT input had not been sought to ensure that every effort was made to identify the underlying cause. The person in charge/provider nominee was requested to arrange for a comprehensive assessment for one resident. This was previously addressed in the action under Outcome 5: Social Care Needs in the context of assessment of residents' needs.

Incident forms were completed in relation to incidents involving behaviours that may challenge. There was evidence that the recording and analysis of such information was used in a positive way to inform supports provided to residents and to prevent or minimise recurrences.

**Judgment:**

Non Compliant - Moderate

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**

Health and Development

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

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

**Findings:**

At the previous inspection, residents' relatives informed inspectors that some relatives had paid for private appointments with the speech and language therapist, as cuts to funding had impacted on the ready availability of this service. At this inspection, inspectors found that access to allied healthcare professionals was facilitated.

An inspector reviewed a number of individualised emergency epilepsy management plans developed for residents. The plans outlined individualised information in relation to type of seizure experienced, rescue medicine(s) to be administered and general first aid. However, the inspector noted that the information contained in one of the plans (dated July 2015) was not in accordance with a letter from the resident's consultant. The plan did not adequately reflect the consultant neurologist's recommendations that the emergency services be called in the first instance to ensure a timely transfer to hospital. The plan did not sufficiently outline specific information given in the consultant neurologist's letter to prevent seizures or to reduce the recurrence. The dose of rescue medicine to be administered as outlined in the letter from the consultant neurologist was different from the dose in the resident's emergency epilepsy plan. This posed a significant risk to the resident not receiving appropriate treatment which could lead to a

serious adverse clinical outcome. The provider was required to take immediate action to address this issue and a robust response was received from the provider.

**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):**

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

### **Findings:**

At the previous inspection, it had been identified that the storage of medication keys was unsafe, the expiry date was not present on one container of medicines, the times of administration were not present on a number prescriptions and the maximum daily dose was not set out on the prescriptions of 'as required' medicines. At this inspection, inspectors noted that improvements had been made in relation to storage of medication keys and the presence of expiry dates for medicines. However, inspectors found evidence that the other failings had not been resolved as outlined below.

Medicines for residents were supplied by a local community pharmacy. Staff confirmed that there was appropriate involvement by the pharmacist in accordance with guidance issued by the Pharmaceutical Society of Ireland. There was a medicines management policy, dated August 2015, that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines.

Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. Residents' medication was stored and secured securely and there was a robust key holding procedure. Staff confirmed that medicines requiring refrigeration or additional controls were not in use at the time of inspection. Compliance aids were used by staff to administer medications to residents and were clearly labelled to allow staff to identify individual medicines.

A sample of medication prescription and administration records was reviewed by an inspector. Medication prescription records were legible and many reviewed contained all the required elements under the relevant legislation. However, a number of prescriptions for one resident did not contain a time of administration and this included medicines with a narrow therapeutic index for the treatment of epilepsy.

Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. However, the inspector noted that the medication administration records indicated that a medicine for the treatment of epilepsy had not been administered to a resident on 31 March 2016 with no reason recorded. In addition, a number of medication administration records did not contain the time of administration so it could not be demonstrated that these medicines were administered as prescribed.

Staff with whom inspectors spoke confirmed that many residents were receiving complementary medicines. It was observed that prescriptions were available for some of these medicines which indicated that the prescriber and the pharmacist were aware of these medicines and could assess for any potential interactions or contra-indications. However, for other complementary medicines, inspectors noted that there was no documentary evidence that the prescriber and/or the pharmacist were aware of these medicines and could assess for any potential interactions or contra-indications. In addition, adequate individualised information was not available in relation to these medicines to guide staff in relation to the safe administration and monitoring of these medicines. Furthermore, administration records for these medicines did not adequately outline the medicine administered and the time of administration.

Inspectors observed that residents were prescribed 'as required' medicines and prescriptions contained many of the required elements. However, the maximum daily dose outlined for some of the medicines was the maximum licensed daily dose rather than the individualised daily dose. For example, for one resident, the maximum daily dose outlined for a psychotropic medicine was 16 times the dose prescribed. Therefore, there was a potential risk that residents could inadvertently receive medicines at a much higher dose than that intended by the prescriber which could have a serious adverse outcome.

There was evidence that residents were offered the opportunity to take responsibility for their own medicines and appropriate assessments were in place.

Staff outlined the manner in which medications which were out of date or dispensed to a resident but were no longer needed are stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal.

**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 the management structure required review. In addition, a bi-annual review of the quality and safety of care and support provided in the centre had not been completed by or on behalf of the provider.

The structure comprised a Board of Directors (which was made up of parents), a director of services who was identified as a person participating in the management of the service and a person in charge who also fulfilled the role of provider nominee for the service in all of its interactions and representations with HIQA. There were two social care leaders in the service, of which the person in charge/provider nominee was one. The person in charge/provider nominee reported to the director of services.

The person in charge/provider nominee was qualified and experienced in supporting residents with a disability. She held a degree in developmental disabilities and a counselling qualification. She had yet to complete a management qualification.

At the time of inspection, the person in charge fulfilled the roles of both the person in charge and provider nominee of the service and was also working on the roster providing direct support to residents approximately half-time. The director of services told inspectors that this arrangement had been put in place in December 2015 in response to a crisis situation and agreed that it was not a sustainable arrangement. Given the non-compliances identified on this and the previous inspection, it was not demonstrated that the current management structure sufficiently supported the fulfilment of the roles of the person in charge and provider of the service, in accordance with the regulations.

In response, the director of services told inspectors that a review of the management structure was in progress. Changes already being implemented from the review included the creation of team leader posts and a review of the role of the person in charge/provider nominee. Of note, the director of services was in the process of preparing a notification to HIQA that would nominate her as the provider nominee.

Inspectors reviewed a report from a review that had been completed in October 2015, which the person in charge/provider nominee said was the annual report. The review considered key areas of the standards and identified areas for improvement. The review involved consultation with family members. However, the requirements of the regulations were not met in terms of review of the quality and safety of the service being provided, which requires a bi-annual review and the production of a report arising from such a review.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

The failing identified at the previous inspection that related to the provision of resources had been satisfactorily addressed.

At the previous inspection it was found that sufficient resources were not available to facilitate residents to engage in activities of their choice or to participate in the community.

At this inspection, inspectors reviewed residents' activity schedules and activity logs and spoke with staff and found that residents were supported to participate in the community in accordance with their wishes and preferences. Activities included going for walks, drives, to the pub or for a meal out, to a nearby Wildlife Park or other parks, to the cinema or for a trip on the train. Where activities were missed, a record was maintained for review by the person in charge. Residents also participated in housework, gardening and helping out with 'odd jobs' around the grounds. While many day services were offered on-site (including art, pottery, gardening, use of outdoor fitness equipment and horticulture), some residents accessed day services run by other service providers. Where transport was shared between different premises, a schedule was available that identified when transport was available for each premise. The schedule in one such premise identified that transport was available for four hours each Saturday and for seven hours on a Sunday, in addition to set times each weekday.

**Judgment:**

Compliant

**Outcome 17: Workforce**

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



**Theme:**

Responsive Workforce

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

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

**Findings:**

Non-compliances relating to staffing arrangements identified at the previous inspection had been adequately addressed. Further improvement was required to address gaps in staff training.

At the previous inspection, an immediate action plan was issued in relation to staffing arrangements. At this inspection, inspectors found that the actions as outlined in that action plan had been implemented. Additional core and relief staff had been recruited. A designated relief panel had been developed to provide continuity of support to residents. Required support ratios had been reviewed, based on risk assessment and care and support needs. Positive behaviour support training was being rolled out. A new induction programme had been introduced for new staff, including the supervision of new staff via shadowing. Inspectors spoke with a number of staff who said that they were satisfied with the staffing arrangements in place. In areas where there were high rates of incidents at the previous inspection, these incident rates had significantly reduced. Staff and the person in charge attributed this to changes in the staff team, staff training, continuity of staff in those areas resulting in a consistent approach to positive behaviour support, input in relation to behaviour support for residents and involvement of more experienced staff in certain premises.

As previously mentioned under Outcome 5, it was not demonstrated that the staff skill mix was adequate meet all residents needs. The person in charge/provider nominee was requested to arrange for a comprehensive assessment of residents with complex healthcare needs in order to determine whether nursing care was required.

At the previous inspection, gaps in mandatory training for staff and other training as required to support residents' needs were identified. While training had been provided for staff since the previous inspection, some training remained outstanding at this inspection. As previously mentioned, there were gaps in fire safety and infection control training. Two relief staff required training in the safeguarding of vulnerable adults. Gaps were also identified in relation to positive behaviour support, food safety and manual handling. Training records indicated that staff were up to date in relation to medicines management, including the administration of rescue medication. A number of staff had received other training relevant to their role and supporting residents, such as in relation to an introduction to autism and autism and sexuality.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

No actions were required from the previous inspection.

**Findings:**

The inspectors noted that the medicines management policy did not comprehensively outline the management of complementary therapies, topical preparations, ear drops and suppositories which were actively prescribed or in use in the centre at the time of the inspection.

**Judgment:**

Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

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

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Cork Association For Autism
<b>Centre ID:</b>	OSV-0002113
<b>Date of Inspection:</b>	04 May 2016
<b>Date of response:</b>	03 June 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:**

Inspectors found that the practice of seeking consent from residents in relation to social and healthcare interventions was not in line with national guidance applicable to community and residential settings, such as the national consent policy 2014 published by the Health Service Executive (HSE).

<sup>1</sup> 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 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

1. Review Medication Management, Personal and Intimate Care, Risk Management, Restrictive Practices, Vulnerable Adults and Health and Safety policies in light of the HSE National Consent Policy 2014.
2. Work with individuals to expand their communication skills, increase their capacity for choice and consent and knowledge of their rights and entitlements.

**Proposed Timescale:** 31/08/2016

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

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

The follow-through of MDT recommendations as they related to communication required review as not all recommendations were being implemented.

**2. Action Required:**

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

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

1. Review all MDT recommendations to ensure that these have been followed or that there is a documented evidence-based decision as to why this has not occurred.
2. Design a Periodic Service Review to track implementation of the MDT recommendations and outcomes.

**Proposed Timescale:** 31/08/2016

**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:**

Written contracts of care were not in place for residents that outlined the services to be provided and the fees to be charged.

**3. 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:**

1. Send out communication to individuals and or their representatives as is appropriate regarding contracts of care that will be put in place initially for 12 months.
2. Invite all individuals and their representatives to an open meeting regarding the contracts of care.
3. Opportunities will be given to each individual and/or their representative for an individual information session to explore any queries.
4. Advise individuals and their representatives that contracts must be signed by July 18th 2016.
5. Explore various options for representatives in light of the HSE National Consent Policy 2014, if appropriate.

**Proposed Timescale:** 31/07/2016

**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 residents' needs had not been carried out by an appropriate healthcare professional. The person in charge was requested to arrange for a comprehensive assessment to be completed for all residents in the centre, and for such assessments to be completed for individual residents with complex needs as soon as possible.

**4. 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:**

1. Individuals with complex needs will have a comprehensive review of their support needs by the professionals involved, inclusive of the relevant medical professionals and mobility professionals where relevant by 23 June 2016.
2. For the individuals with complex needs, the comprehensive care plan will be informed and prescribed by the case conferences held on June 23rd 2016.
3. This plan which will include the identified required multidisciplinary inputs will be in place by the 30th of June.
4. Both the minutes from the case conference and the agreed action plan developed at the case conferences will be forwarded to HIQA by June 27th 2016.
5. For all other service users, a comprehensive evidence-based assessment of each individual's health, personal, social and developmental needs will be completed by August 31st 2016.
6. The needs identified for each individual will prescribe the multidisciplinary input required for the development of their care plan.

7. The professionals involved will determine through their own assessments the level and type of input required to meet the needs of the individual.
8. Additionally this comprehensive assessment and planning process will identify the required skill sets of the support staff and prescribe the skill set and type of staff that support that individual.
9. This comprehensive assessment and planning process will be re-implemented annual.

**Proposed Timescale: 30/09/2016**

**Theme: Effective Services**

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

The supports required to meet residents' needs were not based on a comprehensive assessment of residents' needs, for example, in relation to MDT or nursing supports.

**5. 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. Individuals with complex needs will have a comprehensive review of their support needs by the professionals involved, inclusive of the relevant medical professionals and mobility professionals where relevant by 23 June 2016.
2. For the individuals with complex needs, the comprehensive care plan will be informed and prescribed by the case conferences held on June 23rd 2016.
3. This plan which will include the identified required multidisciplinary inputs will be in place by the 30th of June.
4. Both the minutes from the case conference and the agreed action plan developed at the case conferences will be forwarded to HIQA by June 27th 2016.
5. For all other service users, a comprehensive evidence-based assessment of each individual's health, personal, social and developmental needs will be completed by August 31st 2016.
6. The needs identified for each individual will prescribe the multidisciplinary input required for the development of their care plan.
7. The professionals involved will determine through their own assessments the level and type of input required to meet the needs of the individual.
8. Additionally this comprehensive assessment and planning process will identify the required skill sets of the support staff and prescribe the skill set and type of staff that support that individual.
9. This comprehensive assessment and planning process will be re-implemented annual.

**Proposed Timescale: 30/09/2016**

**Theme:** Effective Services

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

The review of the personal plan was not multi-disciplinary.

**6. 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:**

1. The comprehensive evidence-based assessment of each individual's health, personal, social and developmental needs will be reviewed within four weeks of the anniversary of the implementation of the care plan (see Action 5 & 6 for development of plan).
2. This review will be multidisciplinary and include input from relevant disciplines and all disciplines involved with the individual.
3. This assessment and review process will be completed on an annual basis and will be a multidisciplinary process.

**Proposed Timescale:** 01/09/2017

**Theme:** Effective Services

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

It was not demonstrated that the designated centre met the needs of all residents. Where residents had mobility and healthcare needs, it was not demonstrated that the skill mix of staff or the design and layout of the premises met residents' needs.

**7. Action Required:**

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

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

1. Individuals with complex needs will have a comprehensive review of their support needs by the professionals involved, inclusive of the relevant medical professionals and mobility professionals where relevant by 23 June 2016
2. For the individuals with complex needs, the comprehensive care plan will be informed and prescribed by the case conferences held on June 23rd 2016.
3. This plan which will include the identified required multidisciplinary inputs will be in place by the 30th of June.
4. This comprehensive assessment and planning process will identify the required skill sets of the support staff and prescribe the skill set and type of staff that support that individual.

Premises for residents with Mobility needs & Complex Healthcare needs

1. Service will cease being provided in any premises where the design and layout do not meet the needs of individuals with mobility and complex healthcare needs on July 4th

2016.

2. The support needs, staff skill mix and building design and layout needs of individuals with mobility and complex healthcare needs will be assessed and identified by the relevant professionals by 30th June 2016.

**Proposed Timescale: 04/07/2016**

**Theme: Effective Services**

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

Information in health care plans would not effectively guide staff to support residents.

Health care plans had not been developed in line with each resident's assessed needs.

**8. Action Required:**

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

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

1. A comprehensive evidence-based assessment of each individual's health, personal, social and developmental needs will be completed by August 31st 2016.
2. This assessment will identify the health care needs of each individual and the health and medical inputs required including assessments, and care planning.
3. Care plans will include comprehensive protocols to guide staff in effectively supporting the healthcare needs of residents.
4. These plans will be completed by 30th September 2016.

**Proposed Timescale: 30/09/2016**

**Outcome 06: Safe and suitable premises**

**Theme: Effective Services**

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

Where residents had mobility needs, not all parts of the centre that provided residential or respite care were designed and laid out to meet those residents needs.

**9. 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. Service will cease being provided in any premises where the design and layout do not meet the needs of individuals with mobility and complex healthcare needs on July 4th 2016.
2. The support needs, staff skill mix and building design and layout needs of individuals with mobility and complex healthcare needs will be assessed and identified by the relevant professionals by 30th June 2016.

**Proposed Timescale:** 04/07/2016

**Theme:** Effective Services

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

A shared premises did not meet all of the requirements of Schedule 6 of the regulations. There was limited communal space in one shared premises. Two residents shared a single open-plan kitchen/dining/living space. The action relating to a second living area in the shared premises has yet to be completed.

**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. Individualised separate living areas will be provided to the residents currently in a shared premises with insufficient communal space. This involves building works
2. Building works to be completed by September 30th 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:**

Actions were required in relation to the assessment, management and on-going review of risk:

Individual risk assessments viewed were outside of their review date and referenced staff who no longer worked in the centre. In this way, it was not clearly demonstrated how the effectiveness of control measures were reviewed and informed staff practices or supports provided to residents;

A health and safety risk assessment was to be completed by an external health and safety consultancy.

An updated manual handling assessment for a resident was to be completed by a physiotherapist.

**11. 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. Updated manual handling assessment for a resident (June 2016).
2. External Health and safety audit completed and actions developed (Audit commenced on May 25th 2016 - ongoing at time of writing).
3. Review Risk Management Policy to include a robust mechanism for assessing, managing, reviewing, learning and escalating risks (July 2016).
4. Formulation of a Health and Safety risk management group to meet on a monthly basis (August 2016).
5. Review of all current risk assessments, including controls (June 2016).
6. Development of a schedule of risk monitoring for each individual (August 2016).
7. Identify and risk assess known potential emergencies and develop individual plans to respond these situations (July 15th 2016).

**Proposed Timescale:** 31/08/2016

**Theme:** Effective Services

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

There was a lack of a systems based approach to medication safety.

**12. Action Required:**

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

1. Review of Risk Management Policy including developing a system for analysing serious risks and patterns of risk, identifying the learnings and disseminating this across the organisation (July 2016).
2. Review of Medication Policy (July 2016).
3. Quarterly review of medication errors by medication trainer (June 2016).
4. System developed for the dissemination of findings and learnings and practice from the quarterly analysis of medication errors. System detailed in the Medication Management Policy (July 2016).
5. Medication errors categorised as serious will generate an immediate review and identified and disseminated learnings across the organisation (June 2016).
6. Monthly audits of medication management will be completed (June 2016).

**Proposed Timescale:** 31/07/2016

**Theme:** Effective Services

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

The infection control policy required further development to reflect national standards for the prevention and control of healthcare associated infections and the service's own practices in relation to infection control, for example in relation to staff training, hand hygiene assessment and how/when to access infection control advice.

**13. 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. Review and expand the Infection Control Policy
2. Train all residential staff in Infection control and Hand Hygiene Assessment.
3. Include Infection Control and Hand Hygiene assessment in the training schedule

**Proposed Timescale:** 31/07/2016

**Theme:** Effective Services

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

Personal emergency evacuation plans required review. A sample plan reviewed for a resident with mobility needs did not outline how that resident would be evacuated in the event of a fire.

**14. 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. Identify and risk assess known potential emergencies and develop and or update individual plans, including evacuation plans to respond these situations ( July 2016)
2. A wheelchair accessible emergency exit door will be in place for locations utilised by any residents with mobility needs and wheelchair users. This will be in place by 9th June 2016.
3. All completed personal emergency plans to be reviewed by the Health and Safety officer ( July 2016)

**Proposed Timescale:** 31/07/2016

## 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:**

The person in charge had not ensured 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:

Training records indicated gaps in relation to the safeguarding of vulnerable adults and positive behaviour support;

Inconsistencies were noted in relation to the quality of behaviour support plans;

Some residents who required behaviour support plans had different protocols in place, but not a behaviour support plan that considered all aspects of positive behaviour support.

### **15. 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. Review of Positive Behaviour Support policy to ensure that this guides consistency of practice and includes a template for assessment and behaviour support plans (July 2016).
2. Review all existing behaviour support plans in light of amended Positive Behaviour Support Policy and to insure active implementation (July 2016).
3. Development of an annual training calendar for mandatory training (July 2016).
4. All identified residential staff to complete all mandatory training (July 2016).

**Proposed Timescale:** 31/07/2016

## 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:**

Emergency epilepsy plans reviewed were not all in accordance with the resident's consultant neurologist's recommendations.

### **16. 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. Emergency epilepsy plan was reviewed with Neurologist, GP and individual's representative and amended plan signed off. All relevant staff informed of changes. Review date set.

**Proposed Timescale:** 09/05/2016

**Outcome 12. Medication Management**

**Theme:** Health and Development

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

Practices in relation to complementary medicines were unsafe.

The maximum daily dose outlined for some of the medicines was the maximum licensed daily dose rather the individualised daily dose.

A number of prescriptions for one resident did not contain a time of administration.

Medication administration records indicated that a medicine for the treatment of epilepsy had not been administered to a resident on 31 March 2016 with no reason recorded.

A number of medication administration records did not contain the time of administration so it could not be demonstrated that these medicines were administered as prescribed.

**17. 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. Review of Medication Policy including the use of complimentary medicines and the practices and protocols relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines (July 2016).
2. Monthly audit of medication management, including Kardex and Administration records (July 2016)
3. Annual pharmacist review (7th June 2016).

**Proposed Timescale:** 31/07/2016

## 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:**

A clearly defined structure was not in place that ensured that the requirements of the persons in charge and provider nominee would be fulfilled.

**18. Action Required:**

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

1. Representative of the Provider will remain as currently
2. The Person in Charge will transfer to a current person participating in management who is based in the centre.
3. Team Leaders are active in each support team since May 30th 2016.

**Proposed Timescale:** 30/05/2016

**Theme:** Leadership, Governance and Management

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

An unannounced visit to the designated centre at least once every six months or more frequently had not been completed, that resulted in the development of a written report on the safety and quality of care and support provided in the centre and a plan to address any concerns regarding the standard of care and support.

**19. 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:**

1. Six monthly unannounced visit to be completed and action plan developed ( by 30th June 2016).
2. Written report produced from the findings and a plan prescribed by these findings active (July 2016).

**Proposed Timescale:** 31/07/2016

## Outcome 17: Workforce

**Theme:** Responsive Workforce

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

Training records indicated that there were gaps in mandatory training other training as required to support residents' needs.

**20. 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. Development of an annual training calendar for mandatory training.
2. All identified residential staff to complete all mandatory training.

**Proposed Timescale:** 31/07/2016

## Outcome 18: Records and documentation

**Theme:** Use of Information

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

The medicines management policy did not outline the management of complementary therapies, topical preparations, ear drops and suppositories which were actively prescribed or in use in the centre at the time of the inspection.

**21. 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:**

1. Development of a policy for policy management, including schedule of review for all policies every three years or less as needed and prescribed (September 2016).
2. Review medication policy (July 2016).

**Proposed Timescale:** 31/08/2016