

**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 Camphill Communities of Ireland
<b>Centre ID:</b>	OSV-0003604
<b>Centre county:</b>	Kilkenny
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Camphill Communities of Ireland
<b>Provider Nominee:</b>	Adrienne Smith
<b>Lead inspector:</b>	Noelene Dowling
<b>Support inspector(s):</b>	Rachel McCarthy
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	20
<b>Number of vacancies on the date of inspection:</b>	1

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
25 May 2016 09:30	25 May 2016 20:00
26 May 2016 08:00	26 May 2016 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 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**

The purpose of this inspection was to inform the decision of the Health Information and Quality Authority (HIQA) in relation to the application by the provider to have the centre registered. A full 18 outcome inspection had been planned. However, due to the risks identified and the failure of the provider to meet a wide range of regulations, the inspectors focused on the outcomes that had the greatest impact on the residents. These were primarily safeguarding and risk management governance and workforce.

**Background to the inspection**

This was the second inspection of this centre. A monitoring event was undertaken in 2014. As a result of concerns regarding overall safeguarding systems and responses within the organisation the provider was requested to attend a meeting with HIQA in April 2016. Following this meeting a warning letter was issued and the provider was requested to submit a plan to improve safeguarding systems within the organisation. This was duly received.

**How we gathered our evidence**

Inspectors met with residents and staff and observed practices. Inspectors also reviewed five questionnaires completed by relatives and one completed by a resident

with staff support. All of the responses were very positive regarding the quality of their lives, positive changes which had occurred since coming to live in the centre, the environment and the activities which the residents have access to.

Two of the residents who could communicate verbally with inspectors stated that they enjoyed their activities, went on holidays with staff, and learned new skills and had busy lives. They also said that they knew what staff to tell if they had any issues and that staff would support them. Inspectors observed that residents appeared to be at ease with staff who understood their non verbal communication.

The different dependencies were referred to by some relatives as being of concern and taking up considerable staff time which impacted on their own relatives accessing activities. The level of restriction in one unit was also referenced as placing limitations on access and being noisy at times.

Inspectors also met with the person in charge, the deputy person in charge and the health and safety representative. Inspectors reviewed documentation including policies and procedures, personnel files, health and safety documentation, resident's records and personal plans. Internal action plans and outcome reports on a number of allegations were also reviewed. Inspectors found that the issues identified in this report were known to the provider and plans have been developed to address them. However these have not yet been implemented at the time of inspection.

The actions required following the previous inspection were reviewed. Twenty five actions had been required. While progress had been made on all actions some actions still required review in relation to safeguarding practices.

#### Description of the service

The statement of purpose states that the service is designed to provide long term residential services to children and adults with moderate to severe intellectual disability, people on the autism spectrum and physical and sensory disabilities. The statement also states that in order to create a homely environment persons of different abilities and age groups should be included. One house is currently dedicated to children and younger persons.

Service is provided to 21 residents in five residential units and one individual apartment on their own grounds in a rural area. All of the premises are suitable for propose, well maintained and in tranquil locations.

On the days of the inspection there were 20 residents living in the centre.

#### Overall judgement of our findings

The findings of this inspection are influenced by a number of factors including recent changes o key staff in the units, changes to practices which were planned but not yet assimilated into the practices and structures.

An immediate action plan was issued to the provider due to untrained staff administering a specific emergency medication and insufficient staff trained to administer another emergency medication. This was responded to in a timely manner

by the person in charge.

Overall, inspectors were not satisfied that the provider had put systems in place to ensure that the regulations were being met. This resulted in potential risk for residents in some cases, the details of which are described in the report.

Staff were observed to be committed, tolerant, patient and encouraging of residents at all times during the inspection.

The inspectors found that the lack of effective governance and management systems had resulted in:

- Poor safeguarding measures and medication management systems which could expose residents to risks (outcome 8 and 12)
- Lack of access to clinical oversight of behaviour supports and restrictive practices (outcome 8)
- Lack of access to some allied services which impacted on residents care and development (outcome 5)
- Poor skill mix, experience and systems for supervision and deployment of staff which impacted on the support available to residents (outcome 17)

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

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

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

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

This outcome was not reviewed its entirety. However, a number of findings indicate that practices in relation to this required further attention. There were a number of systems for consultation with residents and there was evidence that their choices influenced their routines and structures on a daily basis.

The ethos of the organisation is of a shared living experience which, it is acknowledged, can have significant benefits for residents. However, in this instance inspectors found that the potential impact of parents who live and work in the centre while simultaneously caring for their small children encroached on the living space and experience of the residents to a considerable degree.

This was observed by inspectors. A number of residents had considerable behaviour issues where the constant presence of small children may in fact exasperate them. There was no evidence that consideration of this impact or that any consultation process had been undertaken in regard to these various living arrangements.

While there were posters advising of advocacy services, no advocates were sourced for residents. In one instance this was strongly recommended by a consultant psychologist early in 2015 where significant decisions were being made for the resident. When inspectors enquired as to why this had not taken place they were informed that the resident could not verbalise so there was no point in doing this. This does not demonstrate understanding of the purpose of advocacy or the need to provide this for such vulnerable residents.

In one of the houses a number of restrictive practices were being used in one location. While this is discussed further in Outcome 8 it was noted that the level of these restrictions had a significant impact on another resident. The door to the bedroom area was locked via a key pad, the door from the resident's bedroom to the fire escape was also locked similarly and there was a loud door censor used at night coupled with an audio alarm.

While there was a reference to the impact on the other resident of these devices there was no evidence that this had been reconsidered or any alternative sleeping or accommodation options considered.

The complaints procedure was on display within the designated centre and residents who could communicate with inspectors stated that they would tell staff of any concerns they had. However, the complaint log seen by inspectors contained two issues neither of which were satisfactorily resolved. One was concerning an incident with a resident and the lack of information provided to the relative in relation to this.

While the person in charge contacted the parent concerned to discuss the issue the complainant was still awaiting incident reports/ details which had not been provided at the time.

In the second issue the complaint was, in the first instance, refereed directly back to the staff member about whom the query was raised. This did not demonstrate satisfactory complaint management or oversight.

Throughout the inspection staff members were seen engaging with residents in a respectful caring and sensitive manner however.

**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):**

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

**Findings:**

The actions required following the previous report in relation to naming those responsible for the implementation of personal plans had been resolved. While systems had been put in place to provide for needs assessment and review some improvements were required to ensure they were implemented.

Annual reviews had taken place for the residents and planning documentation entitled "personal support plans" were implemented. However, the records of the annual reviews did not demonstrate that they were multidisciplinary and took account of any assessments which had taken place or behavioural issues evident for the residents.

The content and outcome of personal planning and reviews differed and was not consistent across the units. Some actions identified at reviews had not been implemented. These included basic activities such as going swimming, or for a short break, or the use of pictorial images to aid communication and understanding or to train staff in sign language. It was stated to inspectors that in some instances these issues were related to the availability of staff but in others the deficits could not be explained.

Inspectors found that referrals and access to some necessary multidisciplinary supports and assessments were not consistent. This included access to speech and language therapists for swallowing issues and psychological supports for behaviours. For example, a resident who required an assessment for swallowing was referred and seen for communication needs. Another resident had not had such a review since 2013. There was a significant deficit in access to psychological assessment and support.

There were need assessments undertaken for daily living skills, behaviour supports, and health care needs. There was evidence that issues identified were being resolved with staff support such as weight gain and sleeping difficulties. There was a suitable transition plan with priority goals for a resident who was moving from the children's unit with emphasis on life skills and development. The personal plan for the younger resident was age appropriate and suitable for the resident's needs. Inspectors found that a recent referral had needs assessment completed prior to admission.

From records available and from speaking with some relatives it was apparent that they were included in the planning process where they wished to participate. Records demonstrated that relatives also attended the annual review meetings.

Residents social care needs were overall well supported with a significant number of activities and meaningful daily routines and occupation. They went on regular holidays abroad, went horse riding and attended numerous events within the centre and in other centres attached to the community. Residents' attended activities or events alone with staff. They participated in the farm work, worked in the gardens did weaving and craft making and baking.

The process of making the personal plans available in an accessible format had commenced for those who required this. Those seen in this format were person-centred and a resident outlined the details of the plan to the inspector.

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**

Effective Services

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

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

**Findings:**

The inspectors found that systems for responding to identified and known risks required some improvement. While there was evidence of review of individual incidents by the person in charge there was no evidence of learning and review or root cause analysis from incidents.

Ten medication errors had occurred since January 2016 with six of these involving failure to administer significant medication and one administered at the incorrect time. While these errors were noted, the actions taken to try to prevent reoccurrences were not satisfactory. These errors were mainly due to either staff communication or knowledge of the need to administer medication.

An immediate action plan was issued to the provider as staff were not trained in the administration of specific emergency medication but were administering this which placed residents at risk of harm.

A serious choking incident had occurred in March 2016. The incident report did not give the full details of the incident, for example, that the resident lost consciousness and emergency services were called. In this instance there was no lasting ill effect for the resident and the house coordinator was available to support the volunteers at the time. However, while the risk management plan for the resident was revised there was no training provided for staff in the management of choking until late May 2016. This did not demonstrate a prompt response to incident management and safety taking the staffing arrangements into account.

Fire safety works which the provider had stated would be completed by June 2016 had not been undertaken. These were based on a plan from the organisations fire safety engineer dated 2014. However, emergency lighting had been installed in one unit as required.

There was a further list of works identified which included the installation of fire doors in significant areas and upgrading of the current emergency lighting in all houses. The inspectors were informed that the priority works would be completed within three months of the inspection. Other works included upgrading of alarms currently in place were considered non urgent and a reasonable time scale of twelve months was

indicated.

There was evidence that regular fire drills were held which residents participated in and documentation seen also confirmed that all fire safety alerting and management systems were serviced quarterly and annually as required. Daily checks of fire exits and the fire panels had recently commenced being recorded. Four staff were not listed on the records available as having fire training however.

Staff were able to inform the inspectors of what they should do in the event of a fire and two residents also explained this to the inspectors.

There was a health and safety officer appointed who undertook audits and inspections of the premises and grounds and overall these systems were satisfactory. Inspectors noted that some windows on the first floors posed a risk to residents or other occupants due to not having suitable restrictors in place. This had already been noted by the health and safety officer and suitable systems were put in place on the day of the inspection.

The risk management policy and emergency plan was satisfactory.

**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:**

Inspectors were not satisfied that resident's safety and welfare was prioritised. While safeguarding plans were evident, the systems had not been implemented at this time, despite the training, the availability of safeguarding officers, a national safeguarding team and revised strategies and policies. Actions from the previous inspection including training in the protection of children had not been addressed.

There were a number of children, both residents and others living in the centre. Inspectors were not satisfied that the risk assessments were comprehensive to ensure the safety of all children living in this environment. The risk assessments available did not consider risks such as the behaviours of residents or the risk of residents inadvertently injuring younger persons and therefore being at risk themselves. One such incident was recorded, which from the records available, did have a potentially negative impact on the resident concerned.

The safeguarding officers had not undergone training in Children First since 2011. This was required following the previous inspection in 2014. While inspectors understand that the provider has requested this training from the HSE and it has not been made available the findings of the risk assessments for younger persons indicate that this is necessary.

Inspectors found evidence that local management had failed to adhere to the policy for the management of an allegation of abuse and staff misconduct. The local management team failed to adhere to the procedures and did not report the allegation to the organisations national team so that it could be robustly investigated.

This allegation was disclosed later via an external source and the person in charge also failed to provide updates and follow up information to HIQA as is required in such situations. The investigation report which was undertaken was reviewed on the inspection and was comprehensive. Some of these findings may be explained by a lack of clarity in the organisation as to the role of local and national safeguarding personnel.

There was a system in place for the management of residents' finances and records of any transactions were maintained. The action from the previous inspection in relation to oversight and monitoring of financial transactions had been partially completed. Inspectors found that the provider was in effect a de-facto guardian in relation to the finances of one resident.

Inspectors found that considerable monies had been removed from a resident's bank account in 2009 as a "contribution". Inspectors were informed that this was in agreement with a person in an informal role of responsibility for the resident. The resident was deemed to be unable to give consent. Inspectors were also informed that it was intended that arrangements would be made to have a legal agreement drawn up in relation to this. However, there was no documentation available to support these statements and no agreement had been drawn up.

In late 2015 the provider sought advice as to whether this legal arrangement should be entered into and was advised that it was not in the organisations interests to do so. An arrangement was made to return the monies in instalments over a three year period. There was still no documentary evidence that any independent person had acted on the resident's behalf in this.

Following the inspection HIQA was informed that the monies had been repaid in full. This was satisfactory and the initial transaction was undertaken in the resident's interests. However, inspectors were very concerned that such an incident had occurred in this manner in the first instance. The lack of advocacy for the resident and failure to

adhere to the agreement for the length of time involved posed a significant risk to this vulnerable resident.

The provider had submitted a safeguarding action plan to the HIQA in April 2016 following a request to do so. While a significant number of the actions identified were not yet due for completion inspectors reviewed the actions which should have been in process. There was posters available advising staff to act responsibly in any issues of concern. The person in charge and designated officers had completed the training in safeguarding vulnerable adults.

An incident monitoring system had been set up and shared learning systems had commenced across a number of the organisations centres. A monitoring system for key safeguarding areas was to have been in place but the outcome of this was not evident.

There was a policy on the provision of intimate care and support to residents. Details of these were available in the personal plans seen by inspectors. From speaking with staff and residents the inspectors were satisfied that the matters were considered in practice and that residents wishes were respected in regard to this.

Residents who could communicate informed inspectors that they felt very safe and well cared for in the centre and relatives also stated this.

There was a policy on the management of behaviours that challenge which was not satisfactory to guide practice. However, the guidelines available for the use of restrictive practices was detailed and in accordance with national guidelines.

A significant number of residents had behaviours that challenge and complex needs. Inspectors found that clinical supports to guide practices in relation to this was not readily available. There were behaviour support plans in place but these were not consistently implemented with assessment and clinical oversight.

While psychiatric support had been sourced there were significant gaps evident in sourcing psychological assessment and review despite high levels of escalating behaviours and the known inexperience of some of the staff to manage such behaviours.

While there was evidence that some external supports in relation to this had recently been sourced this was not evident for all residents who required this. This includes one resident who had a significant specific risk identified. While the management plan was very detailed in this case there was no evidence that the risk factors had been evaluated in some years.

Inspectors found poor practice in relation to the management of restrictive practices. There were a number of restrictive practices used for the management of behaviours and chemical interventions were also used. The latter were prescribed by the appropriate clinicians.

Key pad locked doors, at least five audio listening devices were used and door sensors were also used. In some cases there was a clear rational for the use of the restriction

and in one instance the use of the audio device took account of the need to protect the resident's privacy. This was not a consistent finding however, and there were four individual restrictions being used for one resident to address the same behaviour. In one instance inspectors found that a resident's bedroom door had been locked at night with no assessment or risk analysis of this undertaken. This is no longer occurring. A bed rail was being used which was contra-indicated by the fact that it was known the resident would try to climb over it. The use of the bed rail had not been adequately risk assessed in line with appropriate procedures for the management of restraint.

The practices as implemented do not demonstrate due consideration and required clinical oversight to address the underlying behaviours or seek alternatives to the restrictions. Parents or represented of the residents had signed permission for such usage.

From observation staff were respectful and supportive of the residents and the residents assured inspectors that they felt safe living in the centre.

**Judgment:**  
Non Compliant - Major

### **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):**

No actions were required from the previous inspection.

#### **Findings:**

The provider was compliant with this regulation in terms of residents' overall healthcare needs and residents had access to appropriate general medical and allied healthcare services. Residents healthcare needs were reviewed at a minimum annually and as required. There was good access to GP services and regular monitoring of, for example, bloods where this was indicated. Reviews of resident's health were undertaken and from a review of daily records inspectors found that there was a prompt response by staff to changes in resident's health.

Where a specific care plan for health care needs was required it was available and staff were familiar with the protocols required.

In line with their needs inspectors were satisfied that residents had ongoing access to some allied healthcare professionals including dentists and chiropodists or neurology where required. Records of referrals and reports of these interventions were maintained in residents' files. Referral to other specialists is actioned under outcome 5 Social Care

Needs.

There was evidence that where treatment was recommended and agreed by residents this treatment was facilitated. There was evidence on documentation that residents and their representatives were consulted about their health and medical needs. A protocol was in place for the management of epilepsy and the use of emergency medication. Training for the use of this was detailed and actioned in outcome 7 Health and Safety.

As observed by inspectors and confirmed by the residents the food was nutritious, fresh, choices were accommodated and the mealtimes were social and inclusive occasions. Residents helped to prepare the food with staff assistance where this was necessary and had full access to the kitchens.

Specific dietary needs were identified by dieticians these were seen to be adhered to. Adapted crockery and utensils were available as needed to encourage independence. Inspectors observed that residents were encouraged and enabled to make healthy living choices in relation to exercise, vaccination and healthy eating habits.

While end of life care was not reviewed in full at this inspection inspectors saw that plans were being made to support a resident with increased dependency. Decisions had been made in consultation with the resident's representatives following informed discussions with the clinicians in regard to advanced decisions and actions. The person in charge stated that they had access to the palliative care team and would source additional skill mix as it became necessary. There are two nurses available in the centre.

**Judgment:**  
Compliant

## **Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**  
Health and Development

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

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

### **Findings:**

Inspectors found that improvements were required in medication administration and training for staff. There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines.

Most medication was dispensed in blister packs to support the non-nursing staff. There was identification of medication on each of the medication dispensing pack. However,

inspectors found that P.R.N (as required) medication, in this instance a sedative medication was being administered without the correct prescription being available. This presented a risk to residents as this medication was not included in the blister packs and therefore the correct dosage may not have been administered by staff. This was rectified during the inspection.

While there were protocols for the use of emergency medication training was not provided and this is actioned under Outcome 7 Health and Safety and Risk Management. Inspectors were informed that no residents were assessed as being able to manage their own medication at the time of the inspection. Residents' medication was stored and secured in a locked cupboard in each premises and there was a robust key holding procedure.

Out of 34 staff, training had not been provided to 15 in general medication administration and management. A number of medication audits on individual residents had taken place. These primarily dealt with administration practices and did not consider the use of medication or the medication errors which had occurred. All of these issues are actioned under Outcome 17 Workforce and outcome 7 Health and Safety and Risk Management.

**Judgment:**  
Compliant

#### **Outcome 14: Governance and Management**

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

**Theme:**  
Leadership, Governance and Management

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

**Findings:**  
Inspectors found that while there were governance structures in place improvements were required to ensure they were effective. There was a need for defined roles, responsibility and accountability.

The person in charge was experienced in working with people with disabilities and had been involved in the centre for a significant period of time. She was fulltime in post. Residents were familiar with her and relatives spoken with expressed their confidence in the person in charge.

Inspectors acknowledge the significant commitment on behalf of the management team which was evident. However, the findings on safe guarding, risk management, and workforce indicate insufficient adherence to the regulatory requirements to ensure safe and effective service provision. Inspectors were concerned at the lack of clarity as to roles and responsibilities which was evident in the local governance structure. This was demonstrated by the lack of adherence of the regulatory responsibilities of the person in charge in terms of safeguarding, behaviour supports, asses to assessments and the arrangements for supervision of staff.

A revised supervision policy was to be implemented. While inspectors acknowledge that supervisors had been appointed a review of the records available indicated that the current system was not focused on care and safeguarding and accountability. Inspectors found that the link between supervision and management responsibilities was not clear to those responsible. There was no clarity available to inspectors as to actions taken to address staff issues which could, or had potentially impacted on residents. There was also a lack of clarity as to reporting systems within the organisation and a lack of support for the house coordinators evident.

In discussion with inspectors and from a review of the unannounced visits which had taken place the provider nominee demonstrated awareness of these factors. Plans including additional staff at night time, the revised supervision policy had been put in place to support improvements but the latter had not yet been implemented. Additional management at regional levels is also planned to support the governance arrangements.

As required by the regulations the provider arranged three unannounced visits to the centre since 2015. The latest took place in March 2016. The visits were focused and detailed and reports were made available to the inspectors.

The reports focused on health and safety, premises and residents care needs and staffing issues. Action plans were submitted to the person in charge following this. There was evidence that issues were being identified such as completion of residents needs assessment, the need to review the skill mix of staff and multidisciplinary supports for residents. These had not yet been actioned at the time of this inspection.

A copy of the annual report was made available. This was also detailed and included positive commentary on how residents and relatives viewed the service provided following a survey implemented. However, some issues were not included such as complaint management and reviews of accidents or incidents which would have informed practice.

**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):**

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

**Findings:**

Inspectors were not satisfied that the staffing arrangements, deployment and skill mix was satisfactory to ensure the safe and satisfactory care for all residents. This is despite the obvious commitment and dedication of the staff which was apparent to the inspectors.

The workforce in the centre was a combination of short term volunteers, house coordinators/ long term volunteers and some paid members of staff in accordance with its function and model of care.

The house coordinators have primarily responsibility for the individual units. The training levels ranged from a qualification in social work, psychotherapy and qualification in languages and music. Three staff had social care qualifications.

In response to incidents and behaviours that challenge the provider had recruited some additional night staff due to the need for this support at night. Staff were also assigned to individual residents who required one to one support. There are two registered nurses available in the centre to support the staff with medical care needs.

Inspectors found that while the numbers were satisfactory there was evidence that the skill mix, and the dependency on short term and young volunteers or co-workers was impacting on the residents care. Some residents had significant complex needs and the guidance and skill mix to support these was not evident in all units. While the senior staff who live in the units were available at night and evening it was primarily volunteers who have responsibility at these times. This findings is evident from the number of restrictive practices being utilised and the medication errors and incidents involving staff and residents.

Two of the house coordinators had only been appointed to this role just prior to the inspection and were not sufficiently knowledgeable on the resident's needs or support plans due to this.

A number of the house coordinators live in the centre and have their own small children for whom they cared while they were also providing care for the residents. Some of these staff have significant responsibilities in the units. There was evidence in records

seen and from speaking with staff that this arrangement at times posed a significant challenge to the staff and was on occasion a source of stress. This was observed by inspectors.

Planned and actual staff rosters did not show when staff were on duty. There was no demarcation or boundaries for staff in terms of time off, private time or space within the units. This by extension meant that resident's time and the capacity of staff to be fully available to the residents was limited despite their best efforts. Inspectors were informed that in some instances resident's activities or personal plans were not adhered to as staff had family commitments.

Inspectors acknowledge that changes have been made with the addition of external staff to do sleepovers and attend to residents if they need them at night.

From the training records made available to the inspectors there were deficits identified in the following:

- Six staff did not have training in the use of physical interventions although it was being used on occasions. This included one house coordinator.
- Fifteen staff did not have training in basic medication management.

The person in charge provided a training schedule to inspectors which included additional training on pertinent issues such as self harm and basic first aid.

Systems for supervision of staff were not satisfactory as a support system or to ensure staff carried out their duties. In some instances no records were maintained. Those that were maintained showed the focus was on the community ethos and reflection which does not support residents care or provide sufficient guidance for what was predominantly a young and inexperienced work force.

Inspectors reviewed a sample of staff and volunteer files and found that all the required information such as evidence of Garda vetting was present. New staff were briefed in fire safety procedures and there was a detailed induction programme which included supernumery time for co/workers or volunteers. Co-workers /volunteers were recruited from a number of oversees agency's who specialise in training and support of volunteers. There was a detailed process for recruitment of these volunteers.

Staff were observed to be patient and supportive of the residents at all times.

**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:***

Noelene Dowling  
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 Camphill Communities of Ireland
<b>Centre ID:</b>	OSV-0003604
<b>Date of Inspection:</b>	25 May 2016
<b>Date of response:</b>	5 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:**

There was a failure to adequately consult with residents and their representatives as to their views on the shared living arrangements and the impact of restrictive practices.

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

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

A review of the impact of restrictive practices in the house in question will be carried out in consultation with residents or their representatives. An advocate will be made available to residents to support them in this. An external consultant had been engaged in 2015 in relation to these practices and the report of this consultant will also be reviewed.

Residents or their representatives will also be consulted in relation to the issue of shared living spaces.

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

**Theme:** Individualised Supports and Care

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

There was a failure to ensure that residents who required independent support have access to advocacy when decisions were made in regard to them.

**2. Action Required:**

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

The community will continue to engage the services of the local national advocate who has been involved here since 2014 and who has acted on behalf of a number of residents.

We will encourage and support all residents to access advocacy. Advocacy and rights issues will be brought to the attention of all residents.

We will carry out a training session for all relevant staff on Advocacy to support them in identifying where it might be required.

The community will engage the services of an advocate who can visit on a monthly basis and support residents.

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

**Theme:** Individualised Supports and Care

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

The implementation of the complaint process was not transparent and effective.

**3. Action Required:**

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

In the case of the 2 complaints referred to one has been completed to the satisfaction of the complainant, the other is substantially complete and it is anticipated that it will be finished before the end of July. There will be an incident learning arising from these complaints which will be shared with management and with the provider.

Our complaints process will be revised to include a procedure for residents which is accessible and age appropriate.

The NCMT co-ordinator has also provided advice on dealing with complaints.

**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:**

Resident did not have on-going assessment including but not exclusive to speech language and psychology, where needs indicated this was necessary.

**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:**

All residents have had comprehensive assessments of needs.

An audit will be done to ensure that referrals are made for all necessary professional assessments and supports for each resident.

The resident referred to has now had a swallow assessment.

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

**Theme:** Effective Services

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

Reviews of personal plans were not informed by multidisciplinary assessments pertinent to the resident needs or changes in need.

**5. 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:**

We will put systems in place to ensure that multidisciplinary input is included and documented in reviews of personal plans. Audit of residents needs for professional support will ensure this.

Frequency of review of personal plans will be quarterly to ensure multi-disciplinary inputs will be considered as required.

A directory of multi-disciplinary services in the area is being compiled to ensure awareness of services available.

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

**Theme:** Effective Services

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

Review decisions and personal plan objectives were not consistently implemented.

**6. 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:**

Review decisions and personal plan objectives will be reviewed on a quarterly basis.

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

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

Risks identified were not adequately responded to in order to prevent re-occurrences.

These included:

- medication errors
- potentially very serious incidents for residents.

**7. 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:**

The Community has introduced the national incident recording log which includes medication errors. This provides for ongoing monitoring and review of incidents. The Provider had issued a Incident Notification Learning in respect of medication errors on 13th of June 2016. This detailed learning points and responses to dealing with medication errors to prevent recurrence. This has been brought to the attention of Ballytobin management group by the Person in Charge.

The register of incidents will be reviewed monthly by Medication Co-ordinator and will consider root cause analysis of incidents, case management practice, management of risk and learning. A quarterly review and learning report will also be considered by the Management Group and the Provider.

There will be a training provided in the recording of incidents to prevent important information being appropriately notified.

Our system for responding to emergencies will also be reviewed and communicated to all.

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

**Theme:** Effective Services

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

Insufficient staff had training in the administration of prescribed and required emergency medication.

Staff were administering emergency medication without having being trained to do so.

**8. 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 following additional trainings have been carried out since HIQA visit on 25/26 May 2016:

- Stesolid Administration – 8 people (26/05/2016 and 31/05/2016)
- Buccal Midazolam Administration – 3 people (30/05/2016)

The total number of staff trained in the administration of Buccal Midazolam is now 11.

2. A further 3 people involved in the care of individuals who have a risk of requiring emergency medication of rectal Stesolid, who were unavailable, were trained on Tuesday 07/06/2016.

The total number of staff trained in the administration of Stesolid was 11 on 08/06/2016.

3. A more detailed management plan for the administration of emergency medication which will complement the existing protocol was drawn up for each individual by 01/06/2016.

**Proposed Timescale: 08/06/2016**

**Theme: Effective Services**

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

Systems for containment of fires including the provision of fire doors were not satisfactory.

Fire safety management plans had not been fully implemented.

**9. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

A Fire safety management plan had been drawn up an architect specialising in fire safety and was seen by the inspectors on the days of the inspection. Phase 1 will be completed by 26/08/2016.

Phase 2 and 3 will be completed by 31/12/2016

**Proposed Timescale: 31/12/2016**

**Theme: Effective Services**

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

All staff did not have training in fire safety management systems.

**10. 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:**

Induction training for all staff will include; building layout, escape routes, location of fire alarm points and fire fighting equipment, and arrangements for the evacuation of residents and will take place within 3 days of taking up duties.

In addition to existing training a scheduled training for all relevant staff in fire prevention and emergency procedures and use of fire fighting equipment will be planned to take place three times annually.

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

## 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:**

Staff were not consistently provided with clinical guidance and support for implementing behaviour plans with residents.

**11. 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. An audit will be performed to ensure that all necessary multi-disciplinary guidance and supports are accessed and these will inform staff members in implementing behaviour support plans. (By 31/08/16)
2. Regular team meetings will be held around each resident with behaviours that challenges. (By 31/08/16)
3. External support has been sought to assess behaviours, guide and support staff in the management of challenging behaviours. (By 31/08/16)
4. An audit of our skill mix has been carried out and is under review to determine what recruitment is needed. (31/08/16)
5. It is intended to recruit a social care co-ordinator with extensive experience of challenging behaviour support. By 31/11/16)
6. An additional training programme will be provided for those working with behaviours that challenge. (Sept 2016 to November 2016)

**Proposed Timescale:** 30/11/2016

**Theme:** Safe Services

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

The impact of restrictive procedures and alternative measures were not considered before such procedures were implemented. Such procedures were not adequately reviewed or risk assessed.

**12. Action Required:**

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

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

- Privacy Impact Statements were in place at the time of the inspection for all (5) residents requiring audio monitoring due to the risk of epileptic seizures.
- The impact and rationale for the use of restrictive practice will be clearly outlined in

the Personal Plan

- All restrictive procedures which have been risk assessed will be reviewed. Any which not have been done will be completed.
- As part of this review any possible alternatives will be considered bearing the safety of the resident in mind. If suitable and less restrictive practice is identified it will be implemented with immediate effect particularly if it can be used for a shorter duration.

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

**Theme: Safe Services**

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

Systems implemented for the protection of residents were not robust or adhered to with regard to the following:

- management of residents' finances
- risk management for younger persons
- protection of residents from potential allegations of abuse
- training for staff and managers

**13. Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

An audit of resident finances will be undertaken by the National Financial Officer.

There will be a training /re-training of all relevant staff in the area of supporting residents with their finances.

Where the provider acts as an agent for a resident who does not have capacity to make informed decisions, an advocate will be engaged before any major decisions are made.

Comprehensive risk assessments for younger people living in the community will be completed.

Safeguarding officers and Person in Charge have done 2 day HSE Safeguarding training.

Safeguarding Training will be provided to all staff on an ongoing basis.

A review of national policy is at present being undertaken.

**Proposed Timescale: 31/10/2016**

**Theme: Safe Services**

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

Staff or designated officers did not have training in the statutory requirements for the protection of children.

**14. Action Required:**

Under Regulation 08 (8) you are required to: Ensure that where children are resident, staff receive training in relevant government guidance for the protection and welfare of children.

**Please state the actions you have taken or are planning to take:**  
Children First training will be accessed by designated officers and relevant staff.

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

**Theme:** Safe Services

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

There was a failure to adhere to national procedures for responding to allegations of abuse.

**15. Action Required:**

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

Person in charge and safeguarding officers have completed HSE safeguarding training and are fully conversant with all national procedures.

Safeguarding Officers and Person in Charge have had dialogue with National Safeguarding Co-ordinator re management of safeguarding.

All recommendations by National Case Management Team will be fully followed up.

**Proposed Timescale:** 22/07/2016

#### **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:**

Lines of accountability and responsibility were not defined or adhered to ensure the care provided was effective and safe.

**16. 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:**

Staff issues in relation to supervision have been addressed.

The role of HR co-ordinator has been identified and a person appointed.

A care co-ordinator has been appointed in addition to existing staff and will take up duties at the end of July.

1. Staff in a position of supervision will be made aware of their responsibility to inform

management of any significant issues. (15/07/16)

2. Each house co-ordinator will receive additional support both on a practical level and through weekly line management supervision. (31/07/16)

3. Lines of authority and accountability will be clearly defined and adhered to. (31/08/16)

4. Specific roles and responsibilities for all areas of service provision will be reviewed and any gaps will be addressed. (31/08/16)

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

**Theme:** Leadership, Governance and Management

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

Arrangements to manage and support staff to carry out their duties and exercise personal and professional responsibility were not implemented effectively.

**17. Action Required:**

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

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

1. Each staff member will be advised a supervisor within two weeks of taking up their post and will receive regular supervision. (By 1/08/16)

2. Each co-worker will receive weekly supervision from house coordinator. (By 31/8/16).

3. Regular team meetings will be held around residents with behaviours that challenge. (By 31/08/16)

4. Additional training programme will be provided for those working with behaviours that challenge, such as self-harm, pica, OCD, restrictive interventions. (From 1/09/16 to 31/11/16)

5. A HR coordinator has been appointed to put in place effective arrangements to support, develop and performance manage all members of staff. (Completed)

**Proposed Timescale:** 30/11/2016

**Theme:** Leadership, Governance and Management

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

Current management systems were not sufficient to monitor and implement a safe and suitable service.

**18. 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:**

Care co-ordinator has been appointed to take up duties from 1/08/16.

The Safeguarding Co-ordinator has been in dialogue with Person in charge regarding compliance with national policy.

Reporting systems and communication will be improved locally and nationally through the use of new IT systems in relation to Safeguarding, Accidents, Behavioural Incidents, Complaints and Medication Errors. (31/08/16)

All members of management group who do not already have management training will commence this. (31/12/2016)

**Proposed Timescale:** 31/12/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Deployment, skill mix and personal circumstances of staff was not considered for its impact on the care of residents' and staff were not supported to manage this.

**19. 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:**

1. We have already begun recruiting 2 house coordinators, night staff for one house, and 3 additional care assistants. (By 31/10/2016)

1. The skill mix in each house has again been reviewed and any deficiencies identified will be addressed. (30/09/2016)

2. A care coordinator has also been appointed to take up duties on 01/08/2016

3. Policy and practice in regard to co-workers/house coordinators who are living in a house with residents has been amended to ensure co-workers will not be on duty when they are minding their own children. To achieve this, in one house an employed house coordinator is being recruited while, in the other a child minder will take on child minding duties when the house co-ordinator is on duty.

**Proposed Timescale:** 31/10/2016

**Theme:** Responsive Workforce

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

Rosters did not precisely state who was on duty and when.

**20. Action Required:**

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

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

The format of rosters will be adapted to state precisely who is on duty and when. This roster will show both employed staff and co-workers.

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

**Theme:** Responsive Workforce

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

There were deficits in is significant training requirements including:

- six staff did not have training in the use of physical interventions
- fifteen staff did not have training in basic medication management.

**21. 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:**

All frontline staff will have training in the use of physical interventions where this is required. (30/09/16)

Not all staff members are required to administer medication but to those who do all receive Basic medication management training by the community nurse who has completed a Medication Management Train the Trainer course. (Completed)

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