## Health Information and Quality Authority Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Little Angels Association Letterkenny</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003924</td>
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<tr>
<td>Centre county:</td>
<td>Donegal</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<td>Registered provider:</td>
<td>Little Angels Association Letterkenny</td>
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<tr>
<td>Provider Nominee:</td>
<td>Geraldine Doherty</td>
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<tr>
<td>Lead inspector:</td>
<td>Thelma O’Neill</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>7</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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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:
20 April 2016 09:30 20 April 2016 19:30
21 April 2016 09:30 21 April 2016 17:30

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

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Summary of findings from this inspection
This designated centre is operated by the Little Angels Association and is a single residential community house, providing full time residential care to seven residents.

This inspection was to assess this service for compliance for registration with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013) (referred to as the Regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (referred to as the Standards).
This inspection took place over two days. As part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident/incident logs, policies and procedures and staff files.

Residents attended day activities in the local day service and some residents attended work in supported employment. Staff supported residents to maximize their independence and encouraged them to make decisions and choices about their lives. Residents were supported to pursue their hobbies and interests and showed the inspector how this was achieved. They described how they enjoyed living in the centre and how they spent their days, commenting positively on the assistance they received from staff.

The premise had been extensively refurbished and redecorated last year. All areas were well furnished and decorated in attractive colour schemes. All residents had their own rooms and there were spacious communal areas that enabled residents to sit together or to have quiet time alone. Residents were aware of the inspection taking place and took the inspector around the house to see the facilities and garden.

The inspector found that the governance, management and financial viability of this centre were a serious concern. The provider nominee had taken leave for a number of months and no appropriate manager had been put in place to manage the centre in their absence. Furthermore, HIQA had not been advised of the absence of the provider nominee or that another acting provider nominee had been put in place. The lack of provider oversight resulted in the person in charge managing this centre without adequate support and supervision.

During this time, the person in charge became aware of the financial shortcomings that threatened the viability of the centre and on the direction of the board members sought additional funding from the funding body. Some funding was secured to ensure the short-term viability of the centre; however, the long-term viability of this centre remains unclear. This issue is discussed in more detail under outcomes 14 and 16.

The inspector met the provider nominee on the first day of inspection. He advised the inspector that he was resigning from the position of provider nominee and introduced the inspector to the new proposed incoming provider nominee. This person was a member of the board of directors. However, the inspector found that the proposed provider nominee was not familiar with the role or the legal responsibility associated with the position of provider nominee and was advised by the inspector that this was a requirement of the regulations.

Findings on inspection identified ten outcomes fully compliant, or substantially compliant, four outcomes non compliant moderate, and four outcomes non compliant major. While there was good evidence of compliance or substantial compliance; the management of risk, safeguarding vulnerable adults, resource management and governance were all majorly non compliant.
The inspector advised the person in charge and the acting provider nominee of the findings of the inspection and in particular, the major non-compliances and immediate actions required; in relation to fire safety, safeguarding, health, safety and risk management and a review of the financial viability of the centre.

The Action Plan at the end of the report identifies those areas where improvements were required in order to comply with the Health Act 2007 as amended and related regulations and standards.
**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

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

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Consultation with residents was facilitated through fortnightly staff/resident meetings. The purpose of these meetings was to establish resident’s choices, opinions and preferences. Residents were consulted and their views were sought on any issues that affected the running of their home.

Residents’ financial affairs were managed with the support of staff and their families and some residents had their own bank accounts with bank cards and individual PIN numbers. They were supported in accessing banking services as needed. The person in charge outlined how residents’ finances were managed in the centre. Each resident’s financial records were checked regularly and an up to date ledger maintained for each individual resident with receipts maintained for all purchases, this was to ensure that residents’ money was appropriately maintained.

Activities available in and out of the centre were age appropriate and reviewed regularly through consultation with residents, their key worker and family. An itinerary of activities was available to residents during this period based on their interests and choices. For example, swimming, shopping, basketball and one resident told the inspector that they had represented Ireland in the world Special Olympics in basketball. All residents had opportunities to engage in activities during the day and evenings.

Bedrooms and bathing facilities had provision for privacy and storage of personal belongings to meet the needs of residents. Bedrooms were personalised to each resident’s taste.
Residents had the opportunities to meet visitors in private if they wished and were facilitated to visit family and friends. A visitor book was maintained and there was an organisation-specific policy and procedures to support this practice as required by Schedule 5 of the regulations.

Complaints policies and procedures were in place to ensure residents were consulted about their care and about the organisation of the centre. The person in charge was the nominated complaints officer. A photograph of the person in charge was placed in a complaints log book in the centre. However, a review of the complaints log showed that all complaints were not fully investigated and the process of interviewing residents following complaints was not adequate to ensure that the complainants concerns were fully addressed.

The inspector also reviewed the complaints policy and procedures and found that the details or contact numbers of the complaints person or appeals officer was not named on the complaints policy. The person in charge was not fully knowledgeable of the procedures and regulations in relation to complaints management or their responsibilities. In addition; the acting provider nominee was not familiar with the regulations surrounding managing complaints and did not have full oversight of complaints in the centre.

**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:**
The organisation had a communication policy which set out to address the total communication needs of all residents. Residents were supported to communicate at all times and the systems in place ensured their individual communication needs were met. For example; one resident had a picture communication sheet, that described in pictures how they felt for example; happy, sad or surprised. This communication tool assisted residents in communicating with others about their feelings.

Residents that required specific communication supports had an individualised communication profile in their personal plan; however, one resident that communicated by non-verbal means regularly engaged in self-injurious behaviour. Staff told the
inspector that some of this behaviour was identified as an inability to express themselves or communicate with others. While the resident had been referred to a speech and language therapist; a communication assessment had not yet been completed. The person in charge advised that the speech and language therapist did not undertake assessments in this area and no alternative referral or other action had yet been taken to address this need.

**Judgment:**
Substantially Compliant

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**Outcome 03: Family and personal relationships and links with the community**
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
Residents had developed links with their local community. Some residents had lived in the centre for many years and regularly visited the nearby shops, cafes and restaurants. Some residents had paid employment and others regularly participated in local fund raising events. One resident who spoke with the inspector described how much they enjoyed their job and the opportunities it provided to meet and chat to a range of different people.

Family links were encouraged and there was written evidence whereby residents’ families attended ‘circle of support’ meetings and were involved in decisions relating to residents lives.

Visiting was unrestricted and encouraged by staff. Some residents visited their friends who were in other designated centres throughout the organisation. One resident told the inspector that they missed their family as they were living in another country and they would like to move to that country to live with their family. The inspector was told by the person in charge that arrangements were in place for the resident to visit their family this year with the support of staff and that it could be a long term goal that this resident could move to live with or be near their family.

Throughout the centre, there were photographs of residents’ family and friends. Some residents had experienced bereavement and told the inspector they had been supported by staff during those times.
### Outcome 04: Admissions and Contract for the Provision of Services

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

#### Theme:
Effective Services

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

#### Findings:
Admission and discharge policies were available in this centre. The inspector was told that prior to this newly renovated house reopening, there were two houses in this centre and the seven residents living in both houses joined together to live in this house.

Each resident had an agreed written contact of care which describes the support, care and welfare of the resident and included details of the services to be provided for that resident and the fees to be charged.

**Judgment:**
Compliant

### 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:
All residents had personal needs assessments and detailed support plans and risk assessments completed. A review of some residents' personal plans showed that
residents’ personal goals were being regularly completed. However, the inspector found that personal planning meetings were held in the day service area and staff members from the residential area were not involved in these meetings. The person in charge told the inspector that she had arranged to attend these personal planning meetings going forward, so that the residents had opportunities to achieve their goals in day and residential services.

Prior to the reopening of this house, one resident had lived in an apartment alone with the support of one-to-one staffing. Following the renovations this resident was moved into this centre to live with six other residents. The manager of the house told the inspector that they had identified that their placement was not suitable for their personal needs and was finding living with six other people very difficult. The manager was actively attempting to identify a more suitable placement for this resident to meet their individual needs.

Judgment:
Compliant

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
This centre was a large bungalow that was renovated in March 2015. The design and layout of the centre was suitable and reflected the contents of the organisations statement of purpose. The centre is located in the centre of Letterkenny town within close walking distance to the local shops, pharmacy, medical centre, hotel and beauticians. There was a large garden and patio area to the rear of the premise.

There was one sitting room and a kitchen/dining/sitting room. It has four bathrooms (one wheelchair accessible). It consisted of eight bedrooms, including one en suite bedroom. However, the en suite bedroom was used by staff as a sleepover bedroom. Discussion with staff and the person in charge indicated that this bedroom would be more suitable for one of the residents that required supervision in the bathroom to better promote their privacy and dignity. The person in charge agreed to review this issue.
Judgment:
Compliant

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:
There were three regulatory breaches identified during the last inspection. These related to the management of individual risks and fire management in the centre. Two of the breaches had been addressed and one remained outstanding.

The risk management policy remained inadequate and did not cover the identification and management of risks; such as, the unexpected absence of a service user; accidental injury to residents, visitors and staff; and aggression and violence. The measures in place to control and manage risks such as self harm also needed to be developed. In addition; the risk management policy and procedure referred to in schedule 5 did not provide sufficient guidance to staff on the procedures in place to manage risk in the centre. For example; reactive strategies following some incidents were not put in place to prevent a recurrence of the incidents.

There was an organisational risk register in place at the time of the inspection. However, the systems in place were inadequate to effectively escalate serious risks, or potential hazards, to the senior management team or the Board of Directors of this organisation. The inspector found that the significant risk that existed in relation to lack of financial resources had not been adequately managed and (both the outgoing and incoming) provider nominee's were unclear as to actual financial shortfall that existed at the time of the inspection or the seriousness of the issue, until the issue was brought to their attention by the inspector.

The fire alarm system had been serviced, no faults were detected. Fire equipment in the centre had been serviced for the residential unit. There were regular day time fire drills completed in the past six months. However, issues identified during a night time fire drill carried out in June 2015 had not been addressed. This was the only night time fire drill carried out in the centre. The risks related to resident's safety in that there was only one staff member on duty at night for seven residents and there was no assessment undertaken as to the ability of one member of staff to safely evacuate residents in the event of a fire.
Furthermore, the inspector interviewed staff members regarding their knowledge of the fire evacuation procedures. One staff member that worked nights was not aware of the proper fire evacuation procedures, or the residents individualised fire evacuation plans which documented the type of assistance they would need during an evacuation of the centre.

The inspector required the person in charge to take immediate action by way of a night time fire drill. This was completed on the night of the inspection to ensure that the staff member on night duty was familiar with the evacuation procedure in this centre. The following day the inspector was told the drill was completed and that it was good learning experience for staff and some additional safeguarding measures for particular residents had been put in place following the fire drill.

There was no infection control policy in the centre and staff had not received training in infection control procedures, despite supporting residents with their intimate care needs and food and nutrition requirements.

**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):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found evidence of allegations or indicators of abuse that had not been managed in a way to ensure the safety of residents. Furthermore, allegations had not been investigated in line with the organisational or national policy and safeguarding procedures. A review of the documentation provided by the person in charge and of the information provided by residents, staff, management, the inspector concluded there was a significant risk to the safety of residents as a consequence of seriously inadequate safeguarding arrangements in the centre. For example; the person in charge and the acting provider nominee of the centre were not familiar with the national guidelines and procedures to investigate allegations of abuse. Furthermore; the person in charge told the inspector that she was the designated officer for safeguarding vulnerable adults for this centre; however, she had not received any training in her role as designated officer,
or on their responsibility to follow national guidance to safeguard vulnerable adults. In addition; two staff working in the centre did not have training in protecting vulnerable adults.

The inspector found that some of these failings had impacted on the management of outstanding investigations. The inspector was told of one instance in 2013 where a significant amount of money was misappropriated. Proper protocols and procedures were not followed in investigating this incident; although the social worker was informed of the incident, the issue was not reported to the Gardai, no proper records of the preliminary screening meetings were available and the money had not yet been returned to the resident. In addition; the person in charge did not perceive it as her role to follow up on this issue despite being the designated officer for the centre.

There were two other safeguarding incidents reported in this centre, where significant bruising and marks were observed on a resident. These incidents were not appropriately investigated. The last incident of unexplained bruising occurred in November 2015 and although the incident was reported to the Gardai, the incident has still not been appropriately investigated and the resident and staff had not been interviewed. In addition; staff told the inspector that this resident was not to be left unsupervised and that they were to constantly monitor this resident when in the centre. This safeguarding measure had been put in place in 2013 and the risks to the resident was reviewed in October 2015 and the additional staff supervision was still deemed necessary; however, there was no justification in the records reviewed as to why these safeguard measures were still required.

Furthermore; the inspector also found that there were inadequate local procedures to guide staff in the event of an allegation of abuse being reported. The provider nominee and staff interviewed were unsure of the national procedures to follow in the event of an allegation abuse being reported. For example; the person in charge, acting provider nominee and night staff were not familiar with the national policies and procedures for protecting vulnerable adults. Staff's knowledge of these procedures was important as they are responsible for the care and welfare of the residents in this centre.

The inspector also found that the management of behaviours that challenge was inadequate. One resident was regularly displaying incidents of aggressive behaviour toward their peers and staff members. Two staff members were assaulted and protective precautions were put in place as a safeguarding measure. However, incidents of peer on peer psychological abuse had not been adequately identified and protective measures had not been put in place to safeguard residents to ensure they felt safe and not intimidated by their peers. For example; on the day of the inspection, there was an aggressive incident involving a resident. A review of the care records for this resident indicated that there was an inadequate behaviour support plan in place which lacked appropriate input from a behavioural support specialist. In addition; the person in charge told the inspector that they had identified that this placement was not meeting this individuals needs and had requested that the funder arrange alternative accommodation for this resident.
**Judgment:**
Non Compliant - Major

**Outcome 09: Notification of Incidents**
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe Services

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

**Findings:**
A record of all incidents and accidents was maintained in the centre, however some three day notifications and the change in provider nominee had not been notified to the chief inspector as required by regulation.

**Judgment:**
Substantially Compliant

**Outcome 10. General Welfare and Development**
Residents' opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

**Theme:**
Health and Development

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

**Findings:**
Residents had opportunities for new experiences, social participation, education, training and employment. Residents took part in these activities according to their preferences. One resident told the inspector that they worked in the local garden centre Monday to Friday and had their own jobs, such as delivering the milk and washing cars.

There were daily/weekly activity schedules that outlined the activities that residents attended regularly. Photographs of events attended were displayed and were recorded in residents’ personal files. Residents participated in range of activities depending on their interests. This included visits to restaurants, trips out, swimming, basketball, bowling, exercise sessions, and day to day activities such as cooking at home.
Judgment:  
Compliant

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

Theme:  
Health and Development

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

Findings:  
There were arrangements in place to support residents’ health and residents were supported to attend medical appointments as required including attending a consultant psychiatrist for regular medication reviews. Some residents that lived at home attended their own general practitioner (GP) and their family supported them in attending medical appointments. Other residents attended GPs at the local medical centre.

Health support plans in resident’s files were regularly reviewed and updated and guided contemporary evidence-based practice. Residents also had access to the community multi-disciplinary team such as; physiotherapists, occupational therapists and dentists. However, there was a lack of services in relation to communication assessments by a speech and language therapist and guidance by behaviour support specialists in managing residents that presented with behaviours that challenge. Also, the inspector found that one resident did not like wearing their hearing aid as they found it uncomfortable and chose not to wear it, but there was no evidence that staff had tried to assist the resident in finding an alternative hearing aid.

Another resident was only able to walk short distances before experiencing breathing difficulties and although the staff team were advised to encourage the resident to go for regular walks to maintain their mobility; there was no evidence that a referral had been made to the resident's GP to identify a cause of the shortness of breath and to ensure there was no underlying medical condition present.

Residents’ had a good choice of meals and were fully involved in the planning of the weekly menu with alternative options if they so wished. The inspector found that there was a supply of fresh and frozen food and snacks were available at any time.

Judgment:  
Non Compliant - Moderate
**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

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

**Findings:**
The centre had policies and procedures in place for the management of medication and practices and procedures that staff would adhere to in administering safe medication to residents. Staff who spoke to the inspector were knowledgeable regarding the medication management policy and practices. All medications had been individually prescribed by the resident's GP.

The inspector reviewed a sample of prescriptions/administration charts and medical instructions for staff to administer medications; medication were dispensed directly from the original medication packages and the instructions suitably guided staff practice and met the requirements of the regulations. Non-nursing staff had completed medication training and staff received on-going medication management support in the centre. From a review of a sample of prescription/administration charts, the inspector noted that all medications were individually prescribed and regularly reviewed by the GP. Medications were administered as prescribed to the resident for whom it was prescribed.

A system of recording medication in stock on a monthly basis was in place and this assured managers and staff that medication stock was well monitored. Medication that was out of date was appropriately managed in line with organisational policy and procedures.

Systems were in place to record medication errors and although medication errors had occurred in the centre, the majority were clerical errors. Staff and the person in charge had taken appropriate steps to protect the residents and to ensure that the errors would not reoccur.

Medications were securely stored in a locked cabinet and security measures had been implemented. A log was maintained and updated as residents were prescribed new medications or received prescriptions.

Staff had received training on the administration of medication used for treating seizures and a protocol was in place regarding the procedure to follow in the event of an epileptic seizure for each individual resident. This had been signed by the resident's GP.

**Judgment:**
Compliant
**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a written Statement of Purpose that described the service provided in the centre. However, it did not contain some of the information required by regulations. Omission's included the following:
1. The whole time equivalent rates for staff did not reflect the staff working in the centre.
2. The support and supervision provided at appointments was unclear in the statement of purpose.
3. The staffing arrangements stated in the SOP did not match the staff rosters.
4. The employment history of the PIC was included in the SOP and not required.
5. The structure of the housing association was unclear.
6. The current management structure for the centre was incorrect.

**Judgment:**
Substantially Compliant

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**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:**
There were not appropriate management systems in place to ensure effective authority, oversight, governance and accountability of this centre.
This centre was associated with the local school for children with special needs and was jointly managed by a board of management consisting of nine directors. The board of management was overseen by a chairperson/provider nominee. On the day of inspection, the chairperson/provider nominee advised the inspector that he was stepping down from this role. The inspector was introduced to the new provider nominee. The inspector interviewed the new provider nominee and found that she was not familiar with her responsibilities under the Health Act 2007 as amended and related regulations and standards. In particular, failings were identified in relation to safeguarding, governance and management of the centre.

The person in charge was suitability qualified, skilled and experienced and although relatively new to the service and had experience of managing other disability centres. She was familiar with the Health Act 2007 and related regulations and had good systems in place to ensure the day to day governance of the centre was maintained. However, the person in charge had received only limited support and supervision to maintain the service and to address any issues she had identified.

**Judgment:**
Non Compliant - Major

**Outcome 15: Absence of the person in charge**
*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The person in charge was aware of the requirement to notify the chief inspector if she was absent for more that 28 days.

**Judgment:**
Compliant

**Outcome 16: Use of Resources**
*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

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

Findings:
There was evidence that costs and expenses of running this service were not effectively monitored. This service was funded to provide a five day service, however following the renovation of this house, the seven residents living in both houses were transitioned to move into this house and the opening hours were extended to a 7 day service. However, no additional funds were secured from the service funder to provide this additional service. Furthermore; due to the safeguard measures put in place to protect the residents, an waking night staff had been rostered. The person in charge had identified that the current funding for staffing the centre was inadequate and prior to Christmas 2015 there were insufficient number of staff working in the centre, which resulted in agency staff being used to adequately staff the centre.

The inspector was told by the provider nominee that that there were financial issues in this centre and the inspector found written evidence that that this centre was not appropriately resourced putting the financial viability of the centre at risk. For example; a review of the financial viability of this service carried out by the inspector and validated by the provider nominee demonstrated that the centre was not sufficiently resourced to maintain services at the level currently being provided.

Judgment:
Non Compliant - Major

Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

Findings:
The inspector reviewed the staff roster and numbers and skill mix in the centre and found that in December 2015 there were serious deficits in staffing levels. However, since that time, the person in charge had utilised agency staff to maintain adequate staffing levels in the centre. The person in charge told the inspector that a new staff member was due to start work shortly, which would reduce the use of agency staff.
However, the person in charge expressed concern regarding the long term financial ability to maintain agency staff as well as the funding for the new post that is not included in the current staffing allocation.

The person in charge told the inspector that meeting the specific needs of some residents with behaviours that challenge required constant staff supervision when they were in residence and their support needs were impacting on the social care needs of other residents and required more one-to-one support.

There were three staff on duty in the afternoon on the two days of inspection and they were observed to work well as a team and residents said they liked the staff supporting them. The inspector observed that staff members on duty were very familiar with the residents needs, and ensured that the residents were relaxed and that there was a comfortable environment in the home. Staff skill mix was generally the same during the week, however at the weekends the number of residents admitted to the centre reduced and the staffing levels were allocated depending on the individual residents admitted to the centre for the weekend and their personal activity goals.

The inspector was told by staff that in the absence of the Person in Charge (PIC), the provider was available. However, the inspector found that the provider nominee had been on long term leave and there was no alternative arrangements put in place until recently to manage this centre.

There was evidence that the person in charge had regular team meetings with staff and individual support and supervision meetings were held regularly between staff and the person in charge.

The inspector reviewed a number of staff files. The files showed that some of the recruitment practices did not meet legislative requirements. Documentation prescribed in schedule 2 of the regulations were in place for some staff employed in the centre, but a full employment history, employment contacts and references was not available in the three staff files viewed.

The inspector reviewed the staff training records. Most mandatory staff training was complete; however, two staff did not have training in protecting vulnerable adults. Five staff members were due refresher training in July 2016 and a training schedule was in place to ensure all staff would be trained. No staff had up to date training in risk management and this was required due to the risks identified in the centre. Staff lacked understanding of documenting individual or organisational risks and no staff had training in infection control.

**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.

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Use of Information</th>
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<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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<tbody>
<tr>
<td>Some action(s) required from the previous inspection were not satisfactorily implemented.</td>
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<tr>
<th>Findings:</th>
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<tbody>
<tr>
<td>Written operational policies were in place to inform practice. From reviewing the documentation, the inspector found that all policies required by Schedule 5 were in place although some of the policies and procedures were inadequate and did not provide sufficient guidance to staff. These included for example; risk management, fire evacuation procedures, and the complaints policy. The person in charge told the inspector that she had personally developed the policies and procedures due to the resource issues in the centre.</td>
</tr>
<tr>
<td>The statement of purpose and resident's guide were available in the centre, but required review.</td>
</tr>
<tr>
<td>The centre was insured and the policy was up to date.</td>
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<tr>
<td>Information relating to residents and staff were securely maintained in the office and the residents’ bedroom in the centre.</td>
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<tr>
<td>A directory of residents was up to date and met the requirements outlined in Schedule 3 of the regulations.</td>
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<th>Judgment:</th>
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<tr>
<td>Non Compliant - Moderate</td>
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Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

**Action Plan**

**Provider’s response to inspection report\(^1\)**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Little Angels Association Letterkenny</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003924</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>20 April 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>24 June 2016</td>
</tr>
</tbody>
</table>

**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:**

The name and contact details of the complaints officer or the complaints appeals officer was not included in the complaints policy.

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\(^1\) The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

**Please state the actions you have taken or are planning to take:**
The names and contact details of the complaints officer and appeals officer and committee are now available on the complaints policy.

**Proposed Timescale:** 26/04/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some complaints were not fully investigated and actions put in place to address the complaints in the centre. In addition; there was evidence that some complaints were recorded as closed, but there was no evidence this was to the satisfaction of the complainant.

2. **Action Required:**
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

**Please state the actions you have taken or are planning to take:**
There is now a complaints investigation report that is completed when a complaint arises. It outline: the complaint; Investigation; considerations; actions and complaint status. Complaint status will identify if the complainant is satisfied with outcome or if it needs to be escalated.

**Proposed Timescale:** 01/05/2016

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Communication difficulties experienced by residents were not appropriately assessed to ensure that they had the ability to communicate with others.

3. **Action Required:**
Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.
Please state the actions you have taken or are planning to take:
HSE request for Speech and Language communication assessment denied.
Private SLT resourced. To be in effect by 30.9.16.

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:
The risk management policy did not provide guidance on the management of risks in the centre.

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

Please state the actions you have taken or are planning to take:
Following HSE Risk management policy in interim
In house policy will be complete and in place by 30.9.16

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risk management policy did not identify measures or actions in place to control risks in the centre.

5. **Action Required:**
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
Following HSE Risk management policy in interim
In house policy will be complete and in place by 30.9.16

Proposed Timescale: 30/09/2016
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no infection control policy in place in the centre.

6. 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:
Following HSE Risk management policy in interim
In house policy will be complete and in place by 30.9.16

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff did not identify the proper procedures to follow in the event of a fire.

7. 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:
Individual coaching took place with all staff in relation to fire evacuation procedure.
Staff were also then tested on their knowledge individually in relation to the evacuation procedure. Relief staff are coached and assessed prior to night/sleepover shift.

Proposed Timescale: 24/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Issues identified during a night time fire drill in June 2015 were not follow-up and there was no additional night time fire drill completed to ensure that the issues were addressed satisfactorily.
8. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Night time fire drill was completed on 25.04.16.
Fire drill practising and Monitoring programme was implemented. This consisted of one fire drill a week being carried out between 9th May- 3rd June and the outcome of these being monitored for developing of new Personal evacuation plans and identifying areas of concern.
Personal evacuation plans were updated on the 16.06.16 as a result.
A visual guide was developed for one resident to assist him to understand the importance of the fire drill.
Planning
This visual guide will be reviewed on a weekly basis with the individual as per care plan.
Day time and night time fire drill dates have been identified for the year. These are located in the Diary as well as the Fire Drill section of the Fire folder.

Proposed Timescale: 16/06/2016

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have adequate behaviour support plans and there were no reviews of behavioural management issues.

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

Please state the actions you have taken or are planning to take:
All behaviour support plans (x4) are being developed in consultation with the appropriate professionals (psychology and psychiatry, OT and SLT as appropriate). These are under review on an ongoing basis.
Draft behaviour support plans are in place, but have not been fully approved by a psychologist. Due to issues outside our control, this will not take place until 16.9.16

Fully implemented Resident one: 1.05.16
Fully implemented Resident two: 1.06.16
Fully implemented Resident three: 01.09.16
Fully implemented Resident four: 16.09.16

Proposed Timescale: 16/09/2016
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents that experienced financial abuse were not appropriately supported to develop the knowledge and skills needed for self care and protection.

10. **Action Required:**
Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

**Please state the actions you have taken or are planning to take:**
Resident has been given support to develop an understanding and awareness of money management which is ongoing since the service open a year ago.
Support plan is in place to develop these skills for resident who needs them.

**Proposed Timescale:** 26/08/2016

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
1. The person in charge had not received training in the role of designated officer.
2. Two staff did not have the appropriate training in safeguarding vulnerable adults.

11. **Action Required:**
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**
Two designated officers (PIC and Provider nominee) received training.

Frontline staff are receiving training as per national roll-out.
First training delivered on 13.6.16
Second batch of frontline training on 19.9.16 and third roll-out on 3.10.16
Interim in-house training delivered to all staff on the 17th August 2016

**Proposed Timescale:** 03/10/2016

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Allegations of abuse were not appropriately investigated and remain open without proper procedures or timelines in place.
12. **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:**
Meetings have taken place to discuss the issues outstanding. Investigation is underway in each of the incidents. Further meetings have been scheduled to take place on the 4th July 2016 and subsequent meeting is due on 23rd August 2016. Due to circumstances outside our service control, the date for completion is 1.9.16.

**Proposed Timescale:** 01/09/2016

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**Outcome 09: Notification of Incidents**
**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Three day notifications were not submitted to HIQA as required by the regulations.

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

**Please state the actions you have taken or are planning to take:**
This was in the case of one notification that was sent within three days when staff became aware that it was a ‘concern of abuse’. It had been previously submitted in the quarterly reports as an ‘injury’.

This procedure is actively in place in the unit.

**Proposed Timescale:** 20/04/2016

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**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:
Access to MDT's such as; Speech and Language therapists and hearing specialists required review.

14. **Action Required:**
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.
Please state the actions you have taken or are planning to take:
Assessments needed are accessed through the private market when not available from HSE directly.

**Proposed Timescale:** 24/07/2016  
**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The there was no evidence that one resident that presented with a potentially serious medical condition had not been referred to the General Practitioner.

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

Please state the actions you have taken or are planning to take:
He was referred to GP and family facilitate this appointment.

**Proposed Timescale:** 20/07/2016

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The statement of Purpose needs to be revised to reflect the current service provision.

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

Please state the actions you have taken or are planning to take:
PIC information updated. Provider has approved the temporary hiring of a supervisor and two support workers as an interim measure for three months until recruitment process can fill these posts on a full time capacity.

Planned
The new management structure must be approved by the board prior to being updated. Recruitment process to take place (in three months) to appoint supervisor and two support worker roles to the team.

**Proposed Timescale:** 01/09/2016
**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The governance and management systems in place were not safe, appropriately resourced, or effectively monitored.

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

**Please state the actions you have taken or are planning to take:**
A management committee has been set up (11.8.16) of core members from the board to ensure full oversight of the service.

Planning
Fortnightly, (more frequently when required) management meetings. In place
Management committee meet monthly.
First meeting will meet to set out terms of reference and assign duties to members.
Board is reviewing competencies to identify skill gap. Completion date: 5.9.16
Will recruit to fill these gaps as identified. Completion date: 30.9.16
Annual inspection took place by the provider nominee on 10.8.16 and the report is being drafted. Completion date: 10.9.16

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

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no annual review completed of the service.

18. **Action Required:**
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

**Please state the actions you have taken or are planning to take:**
Annual inspection took place on 10.8.16, report being drafted. Report completion date: 10.8.16

**Proposed Timescale:** 10/09/2016
Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The designated centre is not sufficiently resourced to maintain the level of services provided.

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

Please state the actions you have taken or are planning to take:
Met with HSE to discuss funding request on 17.05.16.
A business case is being prepared for service level agreement rather than grant aid.
Report due: 29.9.16

Proposed Timescale: 29/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two staff had not completed the mandatory staff training requirements such as protecting vulnerable adults and no staff had training in risk management.
The person in charge had not received training as the designated officer, in protecting vulnerable adults.
Night staff required refresher training in fire safety evacuation procedures.

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:
Safeguarding training roll out, as per action 12 took place on 13.6.16, next set is 19.9.16 and the final set will take place on 3.10.16.
Risk management training took place on 14.06.16.
Designated officer training took place on the 20-21 June 2016.
All staff received refresher coaching from PIC in Evacuation procedure and were assessed as knowing the procedure in place fully.

Planned
Risk assessment coaching will take place for staff who were unavailable on 1-20th August 2016.
Full fire safety training is scheduled for the 29th August 2016.

**Proposed Timescale:** 29/08/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Policies and procedures were not present or inadequate and did not provide sufficient guidance to staff. For example; risk management, fire evacuation procedures, complaints policy, and infection control.

**21. Action Required:**

Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

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

HSE risk management and infection control policies in place in interim basis. Personnel have been sought to work on Risk management and infection control. Complaints policy has been amended.

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