

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
Centre ID:	OSV-0003944
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Simon Balfe
Lead inspector:	Julie Hennessy
Support inspector(s):	Geraldine Ryan; Kieran Murphy; Louisa Power
Type of inspection	Unannounced
Number of residents on the date of inspection:	29
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 27 June 2016 09:00 To: 27 June 2016 16:30

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

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
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This was the seventh inspection of this designated centre. This inspection was carried out following the receipt of a notification of an adverse clinical event submitted by the person in charge of the centre to the Health Information and Quality Authority (HIQA).

This inspection was a triggered monitoring inspection. The purpose of this inspection was for inspectors to seek re-assurances that residents' needs, and in particular healthcare needs, were being appropriately assessed and met by the care provided in the centre. The provider had also responded in a proactive manner to the adverse clinical event and commissioned a clinical review of all residents in the centre in order to determine whether there are any unmet needs. The anticipated completion date for that review is 1 November 2016.

As part of this inspection, inspectors also followed up on actions from the most recent inspection in January 2016 and a fire safety inspection in October 2015.

Description of the service

The centre comprises four interconnecting dormer bungalows (or 'units') and is a congregated setting. The centre can accommodate 31

residents and mainly provides a service for residents with a severe to profound intellectual disability. There were no vacancies as the statement of purpose for the centre states that no further admissions will be accepted to the centre.

How we gathered our evidence

Inspectors met residents who lived in each unit. Staff were observed to support residents to use non-verbal communication to express their choices, feelings and wishes. Inspectors met members of the staff team, the person in charge, and clinical nurse managers (CNMs). The director of nursing and assistant chief executive officer attended the feedback meeting at the close of the inspection. Inspectors observed staff practices and interactions between residents and staff and reviewed documentation such as personal plans, healthcare plans, risk assessments and training records.

Overall judgment of our findings

Overall, inspectors found that the provider taken a number of steps in an effort to bring the centre into compliance with the regulations. Supports and resources have been provided to the centre in a number of forms including staff training, increased nursing supports, input from multi-disciplinary and clinical nurse managers from other parts of the organisation and on-going efforts have been made to put in place an effective management structure. The impact of these supports on residents' lives included increased activities, improved advocacy for residents and appropriate safeguarding arrangements. In addition, a phased decongregation plan is being planned to move residents from this centre into community houses.

However on this inspection, inspectors found that some key areas have yet to be satisfactorily addressed in order to ensure that residents were provided with a safe, quality service:

Under Outcome 7: Health, safety and risk management: an immediate action plan was issued in relation to health, safety and risk management. Infection control standards in one unit were not acceptable as the unit was visibly unclean, unsafe manual handling practices were observed and required fire containment works had not been completed since a fire safety inspection that took place in October 2015. The provider responded adequately to the immediate action plan. Fire safety measures implemented by the provider have mitigated against any immediate risk to residents and others.

Under Outcome 11: Healthcare needs, the understanding and implementation of care planning was inconsistent and residents did not have access to psychology supports where required.

Under Outcome 12: Medicines management, the inspector found an occasion where medicines were substituted without staff in the centre seeking clarification from the prescriber.

Under Outcome 14: Governance and management of the centre, effective monitoring and oversight of the centre was yet to be demonstrated in full.

Additional non-compliances were identified in relation to risk management and documentation. Findings are detailed in the body of this report and should be read in conjunction with the actions outlined in the action plan at the end of the report

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

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Inspectors followed up on previous failings as they related to personal plans and the suitability of the centre to meet residents' assessed needs. Overall, inspectors found that some personal plans were at different stages of development to other plans.

Progress had been made in relation to failings regarding decongregation of the designated centre into the community.

It has been previously identified over the course of successive inspections that the designated centre did not meet the assessed needs of all residents due to inappropriate placement, the number of residents in the centre, the incompatibility of some residents living together and the unsuitable space provided by the premises. Issues relating to the unsuitability of the premises in terms of space and layout were not inspected on this inspection.

The finding in relation to the inappropriate placement remained unchanged. The provider has progressed addressing this action by sourcing an alternative service provider where applicable and by submitting an action plan to HIQA in relation to phased decongregation of the centre. In addition, each resident had a comprehensive assessment of needs in relation to transitioning from the centre to the community.

With respect to personal plans, inspectors reviewed a sample of plans in each unit. Each plan contained a written assessment of residents' health and social care needs. An assessment of their personal development needs to demonstrate what residents did each day and whether they were accessing an appropriate day service was not on file in

the centre. Inspectors did find however that a resident who previously did not have access to a day service was now availing of a day service and was reported to be benefiting from that service. Also, inspectors observed that residents could choose what time they wished to attend their day service and late attendance was facilitated by staff.

Each resident had a written personal plan and work in relation to improving personal plans was on-going across the centre and was being supported by training for staff.

For a number of plans reviewed, detailed information was available in relation to what was important to each resident, how best to support the resident, their likes, dislikes and preferences. This information was very specific to supporting residents to communicate and to promote positive behaviour support and inspectors observed the supports being implemented in practice.

Personal plans also contained personal goals, which had been set at a personal planning review meeting. Minutes of review meetings seen reflected that these meetings were attended by the resident, their family representative and their key worker. There was a step-by-step guide in relation to how personal goals would be achieved and what supports would be required and this was a positive development since previous inspections. However, the review of the personal plan was not multi-disciplinary. As a result, the link between a resident's assessed needs, their personal plan and their goals was not always demonstrated. While some goals reflected residents' needs and interests (such as sensory experiences and hydrotherapy activities), a rationale behind other goals was not clear and did not appear to do so. In addition, it was not demonstrated how the effectiveness of the personal plan was evaluated. For example, where the need for 1:1 staffing to help regulate a behaviour of concern had been identified as a goal for a resident, this was not tracked in the monthly review of those goals, making it difficult to see what progress was being made to achieve that goal.

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

Findings:
On this inspection, inspectors found that improvements were required in relation to ensuring effective infection control procedures, safe manual handling practices and adequate fire safety arrangements were in place and implemented throughout the

centre. The person in charge was required to take immediate action to address risks as they related to fire safety and infection control.

An inspection was completed by the HIQA fire and estates inspector on 15 October 2015 to determine the adequacy of the fire precautions in place. This had identified a number of failings. The failings that related to maintaining all fire equipment, building fabric and building services had been addressed. However, additional failings were identified during this inspection as a fire door in one unit was blocked by a wheelchair and excess items were stored in a boiler room including furniture, cardboard, plastic items, bedrails and a chest of drawers. The person in charge was required to take immediate action to address these failings the day of the inspection. The person in charge responded appropriately to this requirement by the close of the inspection.

The failings identified on the previous fire safety inspection relating to fire drill records had not been adequately addressed. Fire evacuation drills were being undertaken involving residents. However, fire drill records examined did not contain sufficient detail to adequately review the fire precautions in place for an evacuation of the centre. Fire drill records were also not kept in a manner in which it could be demonstrated that the centre could be evacuated in a timely manner. Each resident had a personal emergency evacuation plan in place which indicated what assistance they required to evacuate and these had been updated since the previous inspection.

On the previous fire safety inspection, failings were identified in relation to fire detection and fire containment arrangements. The person in charge provided confirmation that some required works had been completed, including division of the roof space and fire stopping of cabling. Inspectors observed that the presence of holes in door leaves had been rectified. However, not all actions had been completed as many fire resistant doors required replacement due to physical damage to the doors, the non-fitment or incomplete fitment of the requisite intumescent fire and smoke seals or a combination of some or all of the above. The provider was required to address the failing relating to the fire and smoke seals within a specified timeframe of one week. The CEO confirmed in writing that this action would be completed within the specified timeframe. In addition, while the installation of automatic fire detection to many of storage rooms had been completed, four storage rooms still required fire detection systems to be installed. The person in charge confirmed that fire detection systems would be fitted two days following the inspection.

The practices in relation to infection control required improvement as one of the units was visibly unclean. For example, the shower chair was stained and unclean, the assisted bath was unclean, the shower trolley was unclean and there was dust and grime on doors, handrails and windows. Bedroom floors were also unclean. In addition, staff with whom inspectors spoke did not demonstrate an awareness of infection control principles and in particular the use of the centre's colour-coded mopping system to prevent cross contamination during the cleaning process or what constituted clinical and non-clinical waste. Also, cleaning rotas in place in this unit had been signed as completed. Finally, slings used by residents to assist them while using a hoist were also unclean. The person in charge was required to take immediate action to address the poor standard of hygiene in this unit so as to reduce the risk of infection to residents. The person in charge responded appropriately to this requirement.

Inspectors also observed a number of obvious hazards, including cleaning agents that were not locked away and sharp instruments (such as scissors) that were stored in an unlocked area. A hoist sling was observed to be frayed. Given the profile of residents residing in this centre, any such substances or implements were a source of harm to residents. Falls risk assessments required improvement and this is further discussed under Outcome 11.

Inconsistent practices were identified in relation to supporting residents with mobility needs across the units. For some residents, moving and handling assessments had been completed or updated for residents with mobility needs. However for other residents, moving and handling assessments were generic and did not outline how to support individual residents' mobility needs. For example, equipment used (such as hoists) were not mentioned nor was the number of staff required to support such needs. Occupational therapy (OT) and physiotherapy reviews and assessments had been completed where required in relation to moving and handling aids and equipment, specialised beds and seating. Input and advice from a manual handling instructor, OT or physiotherapist had been sought for a number of manual handling risks. Most staff were up-to-date in relation to manual handling training. Two staff required refresher training and this will be addressed under Outcome 17. However, inspectors observed unsafe manual handling practices on two occasions on the morning of the inspection that involved unsafe practices when assisting residents from the floor to a chair.

Inspectors reviewed the incident reporting system and noted that there was a clear process in place to ensure that all incidents would be followed up by the person in charge and reported to senior management of the service at a regional level to review for trends.

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:

Staff with whom inspectors spoke demonstrated an understanding of how to recognise and report allegations, suspicions or incidents of abuse. Staff were observed to support residents behaviour support needs in a positive way.

Residents with behaviour support needs had a care plan in place and a sample of behaviour support plans were viewed. However, there had been no multidisciplinary input into behaviour support plans for residents including from a behaviour therapist or a psychologist. Input from other healthcare professionals had been provided in relation to other areas of need that were relevant to behaviour support. For example, support from speech and language therapy (SALT) considered communication requirements and support from occupational therapy reviewed certain types of restrictive practices. A positive approach to reducing restrictive practices in place was demonstrated for a number of residents. Where a resident had increasing behaviours of concern, other possible causes such as pain, constipation, dehydration and the effect of medications had been reviewed by the general practitioner (G.P.) and registrar to the psychiatrist.

However, the full range of multidisciplinary supports were not available as required to support residents with behaviours of concern. Input from a psychologist was required for some residents. For example, a referral had been made to review a resident in relation to increased behaviours of concern in September 2015 (10 months previously) and at the time of inspection, there was no date for when this assessment would be completed. Residents had access to other professionals (e.g. medical or psychiatric) to rule out possible other causes of such changes. However, when other causes were ruled out, input from psychology was not available to support residents needs in this area. This will be further discussed under Outcome 11: Healthcare needs.

In addition, there was evidence that the behaviour support plans for residents were not always being followed by staff. For example, a behaviour support plan for one resident identified that psychotropic medication could be administered as required (PRN). However, the support plan did identify that it was only to be given if analgesia (pain relief) had been offered to the resident. In the records seen by inspectors this support plan had not been followed during a recent incident.

Where restrictive practices were in place, such practices had been assessed by a multi-disciplinary restrictive practices committee and any practices in place were approved by that committee. There was evidence of a number of restrictive practices having been reduced or removed where no longer required.

However and as previously discussed, the occupational therapist had assessed a restrictive practice in place for a resident in July 2015 and recommended 1:1 staffing time to help regulate the behaviour of concern. While a business case had been made to the Health Service Executive (HSE) for this resource, the action was outstanding. As a result, it could not be demonstrated that the least restrictive practice was in place. This will be further discussed under Outcome 11: Healthcare needs.

Training records indicated that the majority of staff had received training in relation to the protection of vulnerable adults with one staff who required this training having a date scheduled to attend the training. All staff had received training in relation to

positive behaviour support.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

At the previous inspection, gaps were identified in relation to the provision of appropriate health care for each resident, having regard to each resident's personal plan. At this inspection, inspectors found that overall, the understanding and implementation of care planning was inconsistent with good practices in some areas and significant failings identified in other areas. Gaps in understanding how to use care planning to direct the care to be given to a resident have been identified on previous inspections and were also found on this inspection.

In the sample of resident healthcare records seen by inspectors each resident had access to a general practitioner (GP).

There was evidence of access to specialist care in psychiatry, with a consultant psychiatrist available to residents as required. Three residents within the centre over the age of 35 years with a susceptibility to developing dementia had recently had dementia screening carried out by a clinical nurse specialist in dementia care. The results of the screening had been sent to the consultant psychiatrist for review.

Where there was an example of a resident who was unwell, it was demonstrated that staff recognised clinical deterioration and were responsive to such signs. Medical advice and treatment had been sought and received in an appropriately timely manner and advice from consultants and specialist services were sought as indicated.

Residents had access to most allied health services that they required. Residents who required review by a speech and language therapist (SALT) had been reviewed both in relation to communication and any difficulties relating to swallowing. Input from a dietician had been provided for residents with dietary needs. Input from occupational therapy and physiotherapy had been provided when requested for residents with moving and handling or mobility needs or in relation to specialised equipment.

However, input from a psychologist was required for some residents. This is an ongoing issue in this centre as the service has been actively recruiting for a psychologist dedicated to this area for some time. Referrals had been by clinicians to psychology departments within other parts of the organisation to support residents with changes in behaviours and to review restrictive practices in place. Of the sample reviewed on the day of inspection, four referrals were outstanding since 2015. The potential impact for residents was that it could not always be demonstrated that the least restrictive practice was in place or that residents had the supports they required in terms of positive behaviour support or reducing self-injurious behaviour.

Inspectors reviewed a sample of healthcare assessments and care plans across all four units. Variations in practice were identified between the four units. For some residents, clinical risk assessments were in use and included risk assessments relating to the risk of pressure sore development, dementia, malnutrition, dehydration and falls. However, a clinical risk assessment had not been completed for a resident who had compromised skin circulation and was at risk of pressure sores. This risk was confirmed by the CNM1.

At the previous inspection, it was identified that the risk assessment tool in use for the prevention of falls was not validated for use for a younger person with an intellectual disability in a non-acute setting. Since the previous inspection, a new screening tool and risk assessment had been developed and introduced. Inspectors viewed a sample of these assessments. The screening tool was comprehensive and identified key risk factors. Where the screening tool identified a risk of falls, a risk assessment was completed. However, this risk assessment was generic in nature and did not outline the measures required to prevent falls for each individual.

Inspectors found variation amongst care plans viewed. Some care plans were very comprehensive including care plans that related to supporting residents with communication, dietary, mobility and intimate care needs. Epilepsy care plans were in line with evidence-based practice. Staff articulated and demonstrated an understanding of how to support residents and were observed to implement the recommendations contained in the aforementioned healthcare plans.

However, care plans did not always reflect changing needs or circumstances. For example for one resident, where a consultant neurologist had advised to maintain a fluid intake chart for two weeks and to administer medication (on a PRN or "as required" basis) if the resident's fluid intake decreased, this recommendation was not completed. The inspector noted that the neurologist's advice had been written into the record of the appointment itself but not also into the care plan and as a consequence, appears to have been missed and not followed through. For another resident, care plans did not reflect prescribed physiotherapy regimes or specific recommendations by the occupational therapist (OT) or speech and language therapist (SALT). As a result, it could not be demonstrated that care was being provided consistently and in accordance with recommendations of the multidisciplinary team.

Where a resident had chronic obstructive pulmonary disease and was prescribed the use of oxygen, a care plan was in place. The care plan advised to check oxygen saturations each morning and administer oxygen if oxygen levels in the blood were less than 90%. However, the care plan was limited. The care plan did not for example provide guidance

for staff in relation to indicators of cyanosis (blue or purple discolouration of the skin or mucous membranes that may indicate a low level of oxygen in the blood), when to administer oxygen at other times (when oxygen levels in the blood may be low other than in the morning) or target oxygen saturations for the individual resident. As a result, the care plan did not adequately provide guidance for staff in line with the prescription (3 litres to be administered as required if oxygen saturations below 90%). An inspector spoke with two care staff were unable to articulate the indicators of when it may be appropriate to administer oxygen or to seek assistance from nursing support. This was particularly relevant as a staff nurse provided cross-cover between two units at night. An example was observed whereby oxygen saturations were not recorded on the medication administration record (as per the centre's guidance) or in nursing notes.

At this inspection, some gaps were found in required healthcare checks and observations. Where a dietician had recommended that dietary intake be recorded for one resident, some records were incomplete. For example, some entries were vague and just read "tea", recording ceased at different times (e.g. at 6pm some days and 9pm other days) and there were no times recorded for another sample viewed. Documentation was not maintained to demonstrate that physiotherapy exercise regimes were carried out in both the day and residential service as prescribed by the physiotherapist and the CNM1 told inspectors that this regime was not being followed in the residential service. In addition, directions relating to frequent repositioning of a resident so as to maintain skin integrity was not maintained and the CNM1 could not confirm that this repositioning was being done. Also, where monitoring of vital signs was required as part of a resident's care plan e.g. recording of daily blood pressure readings, care plans did not specify normal parameters for that resident or what action (if any) was required if readings were outside of normal parameters for that resident.

Where residents received nutritional support via percutaneous endoscopic gastrostomy (PEG), a care plan was in place. Only qualified nurses looked after residents who received nutritional support via PEG tubes. Necessary checks and observations were specified in healthcare plans and were being completed. However, it was identified at the previous inspection that the risk of aspiration was not addressed either within the resident's care plan, as required in accordance with the organisation's nutrition and hydration policy and/or within a risk assessment. At this inspection, this had not yet been addressed. However in practice, staff nurses with whom inspectors spoke demonstrated an understanding of such risks, what signs and symptoms to look out for and what to do in the event of a resident becoming unwell when receiving nutritional support via PEG. In addition, staff had received training in relation to the care of residents with a PEG since the previous inspection.

Where residents had nutritional needs, a dietary plan was in place, regular weights were recorded and risk assessments were available in relation to the risk of choking and aspiration of food. Many residents required assistance from staff with their meals. Staff were observed assisting residents in a sensitive manner and engaged in a positive way with residents throughout the meal. However, due to the small size of the dining room in one unit, a number of residents had their breakfast interrupted to be moved from the dining table to enable other residents to leave the unit.

Residents had a 'hospital passport' to relay key information in the event of an admission to the acute hospital sector. For one resident, the hospital passport reviewed was specific and reflected residents' current needs including in relation to communication, reducing anxiety, continence and healthcare needs. However, for another resident the hospital passport did not reflect changes in the resident's assessed needs e.g. in relation to mobility support and the use of oxygen therapy.

Where residents were at end-of-life, a care plan was in place that clearly outlined medical and personal preferences in the event of a resident's condition deteriorating. Links with palliative care teams had been established where required. Residents who had suffered loss or bereavement were supported by staff and bereavement counselling was available.

Training and support had been provided to staff in relation to the delivery of care in accordance with residents' healthcare plans and that training and support was on-going, including a training session being held for nursing staff the day of the inspection.

Judgment:
Non Compliant - Major

Outcome 12. Medication Management

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

Theme:
Health and Development

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

No actions were required from the previous inspection.

Findings:

The medicines management outcome was examined by a medicines management inspector. A major non-compliance was identified that related to an occasion where medicines were substituted without staff in the centre seeking clarification from the prescriber.

Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland.

There was a centre-specific medicines management policy and had been reviewed in July 2015. The policy detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines. Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. The inspector noted that medicines were stored securely throughout. Medicines requiring

refrigeration were stored appropriately. However, there were seven gaps noted for June 2016 on one unit for the daily recording of the refrigerator temperatures. Therefore, the reliability of the refrigerator was not consistently monitored.

A sample of medication prescription and administration records was reviewed. Medication prescription records were current and contained the information required by legislation. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications. However, the inspector found that medicines were substituted without staff in the centre seeking clarification from the prescriber. The inspector noted a resident had received twice the prescribed dose of a blood thinning medicine (Medicine A). Staff informed the inspector that the liquid preparation of a Medicine A was not available on 22 June 2016 and a tablet form of Medicine A was administered instead. The tablet form administered was a combination preparation which contained two blood thinning medicines (Medicine A and Medicine B). The inspector noted that the resident was also prescribed Medicine B as a single dose in the morning. The medication administration record indicated that the combination preparation and Medicine B were administered on 22 June 2016. Documentary evidence indicated that staff within the centre had not clarified this with the prescriber. The CNM1 who had been on duty that day confirmed that this had not been checked with the prescriber. Due to the potentially catastrophic impact of a resident receiving twice the prescribed dose of blood thinning medicine without adequate medical oversight, the inspector deemed this to be a level of major non compliance.

The person in charge outlined that nursing staff administered medicines. Nursing staff with whom the inspector spoke demonstrated good knowledge in relation to medication management and confirmed that they had completed training in this area. The inspector observed the administration of medicines by nursing staff and saw that the practice was in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais. The nurse outlined the indications of the medicines to be administered and medicines were administered in a respectful manner.

The medicines management policy outlined that residents were encouraged to take responsibility for their medicines, in line with their wishes and preferences. A comprehensive and individualised risk assessment had been completed for all residents which took into account cognition, communication, reception and dexterity. At the time of the inspection, the inspector saw and staff confirmed that no resident was taking responsibility for his/her own medicines. Appropriate controls were outlined in the policy to ensure that the practice was safe.

Staff outlined the manner in which medications which were out-of-date or dispensed to a resident but were no longer needed are stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records. A system was in place for reviewing and monitoring

safe medicines management practices. However, the error as described above indicates that a review of that incident was required so as to identify any learning from the error.

The inspector saw that medication related errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. The inspector saw that a medication related incident had occurred on 24 November 2015 whereby a resident was administered medicines prescribed for another resident in error. The inspector noted that the appropriate immediate response following the incident; the out-of-hours general practitioner service was contacted and the advice given was followed by staff. The incident form indicated that the incident was reported to a CNM2. A review of the incident was undertaken and recommendations were made. Inspectors noted that the recommendations made had been implemented. However, the review of the incident was not adequate; the review was not multi-factorial and focussed on the operator rather than a systems-based approach. Therefore, it was not demonstrated that all aspects of the medicines management cycle had been reviewed to prevent recurrence of a potentially catastrophic medication-related incident and deemed this to be a major non-compliance. The inspector noted that a subsequent incident of a similar nature had occurred on 30 April 2016 which resulted in a resident being transferred to hospital.

Judgment:

Non Compliant - Major

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

On the previous inspection, inspectors found that the management systems in place in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. In particular, on-going house manager absences and difficulties in nurse recruitment were having an impact on the ability of the person in charge to effectively monitor and supervise the quality and safety of the service. Two clinical nurse managers (CNM1 level) had commenced in the centre approximately 11 weeks prior to this inspection. The CNM1s outlined how they were focussing on updating care plans, risk assessments and personal plans in their areas of

responsibility but that this was a slow process. The CNM1s were focussing on areas that they identified as needing priority attention. However, an overall plan with objectives was not articulated to inspectors and it was not clear how the work being undertaken was being implemented in a consistent way across the four units in this centre.

A new service manager had commenced in the service nine weeks prior to this inspection, which is a key role in terms of overall governance and management of the centre. The service manager, whose role involves representing the provider of this service during any interactions with HIQA, demonstrated an understanding of the key challenges facing this centre in a recent interview. In addition, the service manager, CEO (Chief Executive Officer) and Assistant CEO responded proactively and promptly following a recent adverse clinical event in this centre.

At this inspection, inspectors found that while a number of steps as described have been taken by the provider to strengthen the governance and management of the designated centre, the impact of these developments (some of which are recent) have yet to fully demonstrate that the service provided is appropriate to residents' needs, consistent and effectively monitored. As mentioned under Outcome 7, inspectors found that improvements were required in relation to ensuring effective infection control procedures and safe manual handling practices were in place and implemented in a consistent way throughout the centre. As mentioned under Outcome 11, gaps found in care planning and in the documentation, monitoring and recording of residents' healthcare needs was relevant in the context of adverse clinical events that have occurred in the centre.

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:
Inspectors reviewed training records for the 47 staff on the roster. Training records indicated that not all mandatory training and training required to support residents needs had been completed or was up to date.

At the previous inspection, inspectors found that not all staff had received training that met the assessed needs of residents in order to support residents with nutritional needs to eat and drink and to prevent against the risk of choking. More than half of staff (21 staff) had not received training in relation to the relevant course run in the centre, which was entitled "identification and management of feeding, eating, drinking and swallowing disorders in children and adults with an ID (intellectual disability) and dysphagia". Since the previous inspection, many staff had received this training. However, four staff still required the training.

As discussed under Outcome 8, training records indicated that the majority of staff had received training in relation to the protection of vulnerable adults with one staff who required this training having a date scheduled to attend. All staff had received training in relation to positive behaviour support.

In relation to refresher training, two staff required refresher training in relation to medication management, four staff required refresher training in relation to hand hygiene, two staff required refresher training in relation to manual handling. Also, 27 staff required refresher training in relation to fire safety, which was overdue by one month.

At previous inspections, failings relating to the numbers and skill mix of staff were identified. Since the previous inspections, training and support had been provided to staff in relation to key areas, such as advocacy, risk assessment, care planning and personal planning. There was evidence of an on-going programme of staff development in the centre. In addition, nursing supports in the centre had now been increased with two additional nurses commencing the day of the inspection. As a result, a CNM1 would now be assigned to each unit.

However, the report of a recent adverse clinical event indicated that the staff skill mix required review. At the time of the inspection, the provider was in the process of carrying out a review of staff skill mix in the centre to ensure that it met the assessed needs of residents.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

Only the aspects related to the outcomes covered on this inspection were considered. In relation to the medicines administration records, inspectors noted that space was limited to ensure that adequate documentation of the medicines administered could be made by nursing staff. For each time specified, 7 spaces were available to record the medicines administered. Inspectors noted that one resident was prescribed 14 medicines at 09:00 and another resident was prescribed 16 medicines at 09:00.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
Centre ID:	OSV-0003944
Date of Inspection:	27 June 2016
Date of response:	13 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 05: Social Care Needs

Theme: Effective Services

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

The review of the personal plan was not multi-disciplinary. As a result, the link between a resident's assessed needs, their personal plan and their goals was not demonstrated.

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 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:

As an interim measure the C.E.O is establishing arrangements on a contractual basis to support service users of the centre as required.

The Person in Charge with the Clinical Nurse Managers¹ of the centre are working with the staff team on the new P.C.P format which have meaningful evidence based goals. These goals are tracked accordingly with a review date and a named person to ensure their implementation in place. These goals are person centred and based on individual service users identified needs.

Proposed Timescale: 01/11/2016

Theme: Effective Services

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

It was not demonstrated that the personal plan reviews assessed the effectiveness of each plan and took into account changes in circumstances and new developments.

2. 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:

Multi disciplinary team meetings have commenced for each service user as part of Clinical Review in the Centre These meetings include Social Workers, Occupational Therapist, Speech and Language Therapist, Physiotherapists and Dietician. The C.E.O is seeking the support of a Psychologist on a contractual basis for the service users of the centre as required. In the interim support is sought from CNS in Behaviour and Behaviour Therapist from another part of the Service where a need is identified. The Person in Charge has put a Care planning schedule in place where all keyworkers and named nurses have specified dates where care plans are reviewed and updated dates are August 8th, 22nd and September 5th 2016. The importance of this is shared with all staff and is an agenda item for the staff meeting on June 30th 2016 to ensure there is shared learning for the staff team of the centre.

Proposed Timescale: 01/11/2016

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 systems in place for the assessment, management and ongoing review of risk required improvement:

A number of identifiable hazards were present in the centre;

Falls risk assessments did not outline the measures in place to prevent falls for an individual;

Unsafe manual handling practices were observed;

A hoist sling was observed to be frayed.

3. 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 Person in Charge have reviewed all hazards within the centre and those identified during the inspection have been appropriately managed and no longer a hazard. The Person in Charge with the Clinical Manager 1 have commenced work on falls risk assessments as per screening tool. There is a plan in place to individualise risk assessments and these will be reflected in service users care plans with a review date and a named person to review as appropriate. The Person in charge have discussed a schedule for staff of the centre to receive manual handling refresher training on 16th November 2016. Occupational Therapist contacted on 12th July to review manual handling processes/techniques with the CNM1 and key workers.

Proposed Timescale: 16/11/2016

Theme: Effective Services

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

As detailed within the findings, the provider had not ensured that residents were protected from the risk of healthcare associated infection by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

4. 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:

Areas identified in need of cleaning were attended to on the day of inspection. The Person in charge discussed this with the CNM1 on duty a cleaning log was devised and rolled out on day of inspection. Deep cleaning took place in areas identified on July 11th and 12th and is to be rolled out to three remaining Villas The Person in Charge and CNM1's will complete a weekly walkabout to review same. This will be an agenda item at the next team meeting dates 13th, 20th and 27th July and 3rd August 2016.

Proposed Timescale: 01/09/2016

Theme: Effective Services

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

The arrangements in place for containing fires were inadequate:

As identified during a fire inspection in October 2015, many fire resistant doors required replacement due to physical damage to the doors, the non-fitment or incomplete fitment of the requisite intumescent fire and smoke seals or a combination of some or all of the above.

The installation of automatic fire detection to four storage rooms had yet to been completed at the time of inspection.

5. 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:

The Nominee Provider with the CNM3 and the Person in Charge discussed fire regulations with the Director of Logistics who arranged to have smoke detectors installed in four storage rooms on June 28th by an external consultant.

Fire doors were resealed by an external consultant on July 5th, 6th, 7th and 8th to ensure they meet the regulations and safety of the service users.

The service will review the fire doors with a competent person and will revert to HIQA with a plan by 2nd Sept 2016.

Proposed Timescale: 02/09/2016

Theme: Effective Services

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

The arrangements for reviewing fire precautions were not adequate in the following ways:

As identified during a fire inspection in October 2015, the fire drill records did not contain sufficient detail to adequately review the fire precautions in place for an evacuation of the centre;

Materials were stored in a boiler;

A wheelchair was blocking a fire exit route.

6. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Following inspection the Nominee Provider discussed this with the Maintenance Manager the Boiler house has since been cleared – materials remaining are purpose related. Fire evacuation template is to be reviewed and updated by the Health and Safety Officer to identify the length of time an actual evacuation takes as opposed to the total length of time of the full fire drill. This to be discussed at the next team meeting dates 13th, 20th and 27th July and 3rd August 2016 to ensure all staff are familiar with the process.

Proposed Timescale: 01/09/2016

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:

As detailed within the findings, it had not been demonstrated that all alternatives had been considered before putting in place restrictive practices nor had it been demonstrated that this was the least restrictive practice that could be used.

7. 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:

The C.E.O with the Director of Human Resources continue with various options to recruit Psychologist for the service. A psychologist will be contracted for the service users of this centre where a need is identified also the CNS in Behaviour and/or a Behaviour Therapist will be sought from another part of the Service. The importance of adhering to Behaviour Support Plans has been highlighted to all staff at team meeting dates 13th, 20th and 27th July and 3rd August 2016. Multi-disciplinary team meetings have commenced as part of the Clinical Review of the Centre. Restrictive Practices are reviewed by the Restrictive Practice Committee annually or as required. The Person in Charge with the support of the Clinical Nurse Manager 3 will ensure the least restrictive practice is always trialled first this will be documented and signed.

Proposed Timescale: 01/09/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Improvement was required to ensure that appropriate health care for each resident was provided at all times and reflected changing needs or circumstances. Examples were found whereby:

Clinical risk assessments had not been completed for all identifiable healthcare needs;

Monitoring recommended by a medical consultant had not been carried out;

Discussions pertaining to healthcare needs and treatment were recorded in communication diaries and appointment records and not in care plans;

Care plans did not reflect recent reviews by members of the multi-disciplinary team;

Care plans did not adequately reflect instructions by the prescriber of oxygen therapy;

It was not evidenced that recommendations from allied health professionals in relation to re-positioning and exercises were being implemented;

Where residents received nutritional support via percutaneous endoscopic gastrostomy (PEG), the risk of aspiration was not addressed either within the resident's care plan and/or within a risk assessment.

8. 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:

The Person in Charge have ensured the Waterlow Scale's have been updated in each area of the centre Mattress assessments for each service user based on Waterlow Assessment is taking place on July 12th 2016. Individualised. Risk Assessments arising from assessments/screening tools have commenced by named nurses. These will be incorporated in the service users care plan with a named responsible person and a review date in place.

The Person in Charge has discussed the importance of any recommendations from Multi-disciplinary reports and must be documented in each person's care plan and actioned immediately. This was discussed at the care planning staff meeting on 30th June 2016.

The Person in Charge advised all nurses of the centre at the June 30th 2016 staff meeting to document relevant information in care plans and not the communication book. The Person in Charge and the Clinical Nurse Manager1 will review instructions from medical practitioners and oversee that they are carried out as prescribed.

The Person in Charge and the Clinical Nurse Manager 3 will carry out regular audits to ensure this is happening.

Proposed Timescale: 01/09/2016

Theme: Health and Development

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

As detailed within the findings, the full range of multidisciplinary supports were not available as required to support residents with behaviours of concern. Where other clinicians had recommended psychology support and referrals had been made, such support was not available for residents.

9. 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:

The Service continues to recruit for the post of Psychology. In the interim where a need is identified the CEO is sourcing a psychologist on a contractual basis to support the needs of individual service users of the centre as identified.

The support of the Clinical Nurse Specialist in Behaviour will be sought from another part of the Service.

Proposed Timescale: 01/11/2016

Outcome 12. Medication Management

Theme: Health and Development

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

Medicines were substituted without seeking clarification from the prescriber.

The review of a medication related incident was not adequate to prevent recurrence.

10. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

The Person in Charge have advised Nursing staff they must update care plans when communicating with pharmacy and/or GP and not only to document in the communication book. This has been discussed at the care planning staff meeting on June 30th 2016. The Person in Charge and the Clinical Nurse Manager 1 will review practice on the regular walkabout of the centre.

In relation to the identified medication incident the nurse on duty has been referred for and attended training on the Medication Management Policy on 21st June 2016. The nurse has completed Medication Management course on HSEland. Two supervised medication administration rounds were also recommended and 1 has already taken place. 2nd supervised medication administration round to be completed on July 19th 2016. Currently there is a review of medication administration system taking place with Person in Charge and the Clinical Manager 1, Pharmacy and MDT's based on individual service user needs.

Proposed Timescale: 01/08/2016

Theme: Health and Development

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

There were seven gaps noted for June 2016 on one unit for the daily recording of the refrigerator temperatures.

11. Action Required:

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

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

The Person in Charge has discussed the importance of ensuring all daily recordings must be completed daily This is now included in the daily duties. The Person in Charge and the Clinical Nurse Manager1 will carry out spot checks and document same.

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:

As evidenced throughout this report, the management systems in place in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

12. 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 Clinical Review of the Centre was established on June 21st 2016. The Review Committee is led by Simon Balfe Nominee Provider of the centre and includes the Director of Nursing, CNM3, Person in Charge, Quality and Risk Officer, GP and members of the MDT. There is also recognition that an external member of a professional body will be consulted with as required.

Since the day of inspection there are now Clinical Nurse Manager 1 in each of the four areas of the Centre. All four have had a thorough induction. The Person in Charge has full supernumerary status to ensure good governance and management of the centre and the safety and well being of the service users at all times and is supported by the Clinical Nurse Manager 3 and the Nominee Provider on an ongoing basis.

Proposed Timescale: 01/11/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

As detailed within the findings, further review of staff skill mix is required. At the time of the inspection, the provider was in the process of carrying out a review of staff skill mix in the centre.

13. 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:

The Nominee Provider the Director of Human Resources Clinical Nurse Manager 3 and the Director of Client Services have reviewed the skill mix of the centre 5/7/2016 to ensure the appropriate clinical supports are in place to meet the identified needs of the service users. There is a recruitment process in place to recruit Nurses. Interviews are due to take place in August.

The Director of Human resources have drawn up a contract with an agency who are identifying potential nurses for interview. This process is ongoing and will be completed by the end of August to ensure the centre have the appropriate skill mix and full complement of staff

Proposed Timescale: 01/11/2016

Theme: Responsive Workforce

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

Training records indicated that not all mandatory training and training required to support residents needs had been completed or was up to date.

14. 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:

The Person in Charge has discussed training with the training coordinator on 11th July 2016 in relation to outstanding training for staff of the centre as identified by the inspector.

Dates have been set for those with outstanding training needs. The Person in Charge and the Clinical Nurse Manager 1 will keep up-to-date records of staff training in their area and ensure all staff have completed all up to date training as appropriate.

Proposed Timescale: 01/12/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

Space was limited on medicines administration records to ensure that adequate documentation of the medicines administered could be made by nursing staff.

15. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

The Person in Charge has referred the need to review the recording space for documentation on the medication kardex to the next Service Drugs and Therapeutic Committee for discussion on 7th September 2016.

Proposed Timescale: 01/10/2016