

**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 Health Service Executive
Centre ID:	OSV-0005331
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	Jillian Connolly
Support inspector(s):	Stevan Orme
Type of inspection	Unannounced
Number of residents on the date of inspection:	26
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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
11 May 2016 11:00	11 May 2016 21:00
12 May 2016 12:00	12 May 2016 21:30
13 May 2016 11:00	13 May 2016 17:30

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

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

Summary of findings from this inspection

This was a 10 Outcome inspection carried out to monitor compliance with the regulations and standards. The centre consisted of seven houses. The houses had previously been inspected over two separate inspections in March and September 2015. As part of this inspection, inspectors reviewed the actions undertaken by the provider since the previous inspection.

During this inspection, inspectors met with 16 residents. In the main, residents said that they were happy with the service provided although identified a number of areas in which they were not satisfied. Due to the nature of their disability, a small number of residents were unable to express their view on the quality of care provided in the centre.

Inspectors observed staff to engage with residents in a dignified and respectful manner. Inspectors also observed practices and reviewed documentation such as personal plans, medical records, accident logs, complaint logs, minutes of meetings, assessments of risk and staff rosters.

The centre was originally part of a larger designated centre. However at the time of this inspection, a restructuring had taken place. The provider had informed HIQA that one of the houses did not constitute a designated centre. Inspectors visited the house and met with the residents. From the information provided by residents and the governance arrangements in place, inspectors confirmed that it was a designated centre.

Overall inspectors found that the provider had not undertaken the actions as agreed with HIQA following previous inspections. Inspectors found that although residents were happy with the service provided to them, their levels with satisfaction primarily related to the individual staff supporting to them.

Residents told inspectors that there were insufficient staff and despite raising their concerns with management, this matter had not been addressed.

The physical state of the premises was also a primary concern for residents. Documentation and observations of inspectors, confirmed the views of residents. Inspectors also found that there were inadequate governance and management arrangements in place to ensure that the services delivered were safe and effective. There was also an absence of appropriate risk management systems in place.

Fire safety was a concern throughout the centre. Inspectors were sufficiently concerned at the night time supervision levels in one house that they required immediate action to be taken by the provider to address the matter. The evidence gathered throughout the inspection confirmed that staff had not been rostered in sufficient numbers and skill mix to ensure that residents were safe, were supported to meet their basic care needs and to engage in activities in line with their interests and capabilities.

Overall, inspectors found 22 regulatory breaches. Of the nine outcomes inspected, major non-compliance was identified in six outcomes and moderate non-compliance in three outcomes. The details of these findings are in the body of the report and the action required by the provider to comply with the Health Act 2007, as amended and the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities are set out in the action plan at the end of the report.

Given the impact of the regulatory breaches on the safety and welfare of residents in the centre, HIQA took extraordinary action and following the inspection issued a notice of improvement to the provider. This notice set out the immediate actions the provider was required to take ensure that residents were safeguarded.

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 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

There had been two admissions to the centre in 2015. Inspectors reviewed the admission process and found that it was not in line with Regulation 24. The minutes of meetings did not demonstrate that the decision to admit the residents was based on transparent criteria. The support needs that the residents required differed greatly from those of the resident who was previously living on their own in the centre. This resulted in a significant negative impact to the life of that resident. Both admissions were due to be temporary admissions; however one resident was admitted in July 2015. The personal plan for the resident, which was reviewed one week prior to the inspection, did not reference that alternative accommodation was being sourced. The age range of the residents was also considerable. Minutes of meetings further confirmed that residents did not have the opportunity to visit their new home prior to admission.

Inspectors reviewed a sample of written agreements between residents and the provider and found that they were not signed by either party.

Judgment:

Non Compliant - Major

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Inspectors reviewed a sample of personal plans. Assessments were conducted to identify residents' needs. Once a need was identified, a plan of care was created to meet that need. Annual reviews were also held for residents. Goals were identified for residents to achieve in the coming year.

On previous inspections, inspectors found that personal plans were primarily health focused and did not maximise residents' development. Inspectors found that this failing remained. The provider had informed HIQA that a document 'Listen to Me' would be implemented to address this failing. Of the sample reviewed, inspectors found that goals identified remained primarily short term. Examples included going to a hotel over night, going to a concert, going for a walk or attend reflexology. Some of the documents were noted as being incomplete and did not have goals identified. In some instances, residents had identified longer term goals which would require additional supports outside of the standard allocated resources. Examples included having a dog or having their own room. There was no evidence that efforts had been made to achieve these goals.

Inspectors also found that a number of goals had been carried over from the previous year as they had not been achieved.

Inspectors were informed by management and staff that the supports residents required were increasing. Whilst efforts had been made to meet these changing needs through assessment and personal plans, they did not adequately guide practice on the supports residents required. For example, a comprehensive assessment had not been completed for residents following a diagnosis of dementia. However, on review of the plans of care and residents' daily records, inspectors found that recommendations from an assessment by a clinical nurse specialist in dementia had not been implemented in practice. For example, in September 2015, it was recommended that a resident would benefit from one to one support hours. The resident's plan of care only provided for this for personal hygiene. Further, additional support hours had been allocated at the weekend but not during the week. At the time of this inspection, there was one staff member on duty to support five residents.

In regards to the two residents admitted since the date of the last inspection, inspectors found that a comprehensive assessment had not been completed prior to or on admission to the centre for either resident.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The centre consisted of seven houses in close proximity to Sligo town. On previous inspections, inspectors identified that bathrooms and kitchens in two of the houses were not accessible to residents. On this inspection, inspectors found that this failing remained.

Two of the houses were dormer bungalows (1 and 2), three of the houses were two storeys (3, 4 and 5) and two of the houses were bungalows which were connected by a corridor (6 and 7). Inspectors observed that efforts had been made to personalise the houses to reflect the individual preferences of the residents who resided there. However, fundamentally the houses were not fit for purpose. Inspection findings are presented below to reflect the failings identified in individual houses:

House 1:

This house was a four bedroom house and home to five residents. Two of the residents shared a room. The house has two bedrooms on the ground floor and two on the first floor. The house has a sitting room, kitchen/dining room, shower room on the ground floor and toilet on the first floor. Inspectors met with residents who stated that the house no longer met their needs and that they had identified this to senior management. However they had not received a response on what, if any, action would be taken. The primary risk to residents within this house was the stairs. Inspectors observed the stairs to be steep and directly accessed from the door of one upstairs bedroom. Inspectors observed residents using the stairs and it was clear of the significant risk present.

House 2:

This house was a four bedroom house and home to three residents. The three bedrooms on the ground floor are occupied by residents and the fourth bedroom on the first floor is used as a relaxation area for one resident. There was a kitchen/dining room and small utility area. There was also a shower room upstairs and downstairs. Inspectors observed the house to be in a state of general disrepair with external window frames requiring painting and interior décor worn and needing refurbished. There was insufficient communal space considering the incompatible needs of the residents residing there. This resulted in 'house rules' being created which identified specific times in which residents could access the kitchen. The landing was used as a staff office. The

centre was also visibly unclean. The need for a deep clean had been identified by the provider in January 2016 and inspectors were informed that an external company had been contracted to carry this out in the coming weeks.

House 3:

This house was a five bedroom house and home to five residents. There was one bedroom with an en suite on the ground floor and four bedrooms on the first floor. There was a kitchen, dining room and sitting room. There was a bathroom upstairs and a toilet downstairs. Two residents shared a room as the fifth bedroom was used as a staff office/sleep over room. Considering the needs of the residents, inspectors found that the house was not suitable. All residents could not safely access the bathroom to have a shower and instead used the en suite of one resident. This had been identified by inspectors on previous inspections but the provider had yet to address this. The stairs also presented a significant risk to residents residing in this house due to mobility issues. Particular risks for one resident had also been identified in the assessment undertaken by a clinical nurse specialist in September 2015. The assessment stated that an urgent housing review should be carried out. This had not occurred.

House 4:

This house was a five bedroom house and home to five residents. There was one bedroom with an en suite on the ground floor and four bedrooms on the first floor. There was a kitchen, dining room and sitting room. There was a bathroom upstairs and a toilet downstairs. Two residents shared a room, as the fifth bedroom was used as a staff office/sleep over room. Two residents had complained to management about the current accommodation arrangements and said that they would like a room of their own. This request had not yet been facilitated.

House 5:

This house is a five bedroom house and home to five residents. There was one bedroom on the ground floor and four bedrooms on the first floor. There was a kitchen, dining room and sitting room. There was a bathroom upstairs and a toilet downstairs. Each resident had their own room. Areas of flooring were uneven, broken and required replacement. Inspectors were informed that this was to occur in the coming weeks. Inspectors observed the house to be unclean, particularly the bathroom areas. Residents were identified as a risk of falls. The house was located on a steep slope with steps at the front door. This has been identified as a risk by staff and the need for the installation of a handrail was identified. This had not occurred. Furthermore, there was a record of a resident sustaining a fall at the front door.

House 6 and House 7:

Houses 6 and 7 are bungalows with an adjoining corridor. Four residents lived in each bungalow. Each bungalow consisted of four bedrooms each (two of which were en suite), a sitting room, dining room, kitchen and bathroom. In one of the houses the bathroom had been converted to a wet room. The second house contained a bath. The two houses were connected by a corridor. Inspectors observed that there was insufficient communal space considering the needs of residents. There was insufficient room in the kitchens for residents to safely access. The sitting rooms were small and some residents required wheelchairs or comfort chairs. The lack of space was so pronounced that inspectors were unable to leave the kitchen without asking a resident,

who was seated in a comfort chair, to move. A resident in one house used the en suite of a fellow resident as they could not access the bathroom. Inspectors observed insufficient external space to support residents to access the outdoors. Another resident was identified as requiring the use of the sitting room on their own. This could not occur without impacting on other residents.

The records reviewed by inspectors indicated that residents complained repeatedly about the challenges they were experiencing due to the size and layout of the premises.

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

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

Findings:

Inspectors found that the systems in place for the assessment, management and ongoing review of risk were inadequate and resulted in ineffective delivery of service. In each of the houses there was an absence of a systematic assessment of the operational, clinical and environmental risks. Inspectors observed hazards such as the management of controlled medication, an absence of restrictors on upstairs windows, unhygienic external spaces, residents remaining in the house in the absence of staff, staff lone working and staff working for entire weekends with insufficient breaks. There was no assessment in place for these issues and therefore an absence of the necessary control measures.

Of the risk assessments completed, inspectors found that control measures had not been implemented. For example, handrails had been identified as required, but had not been fitted. An alarm was identified as being required for a resident who was at risk of leaving the house without staff. This had not been provided. Individual risk assessments had been completed for residents, however inspectors found that they did not address the fundamental hazards. For example, some residents were identified as being at risk of choking. The control measure was for staff to have basic life skills training. However, not all staff had undertaken this training.

The fire management systems in place throughout the designated centre were inconsistent. In some instances, there was a clear fire plan in place which residents and staff were aware of. In other instances, inspectors were informed by management that the fire procedure was reliant on staff from the neighbouring house. This was not

reflected in the fire plan.

Fire drills did not consistently demonstrate that all residents could be evacuated with the lowest number of staff. In some houses, the fire drills were clear and provided assurances of the safety of residents and staff. In other houses, they did not reflect that all residents could be evacuated in an appropriate timeframe or that drills had been conducted following a change in needs of residents. Residents were very clear on the action to be taken in the event of a fire in some of the houses while in other houses, inspectors found that residents, who were left on their own, were unclear of the need to evacuate. Inspectors brought this to the attention of management during the course of the inspection and it was addressed immediately.

Six of the seven houses had fire doors installed. However, there was an absence of self closers. Inspectors observed some of the fire doors did not close fully. Inspectors also observed that fire doors were wedged open which prevented them from functioning as designed. One house had not been provided with emergency lighting. This had been identified on previous inspections. Inspectors observed that final fire exits were locked by a key and there was no provision of a break glass unit containing a key. This presented a risk of a key to the exit not being available in the event of an emergency.

One house had no fire doors installed. The arrangement in place on the day of inspection was that residents would be supported to evacuate the house by staff in the event of an emergency, However, the staffing arrangement in this house was for one member of staff to sleepover; there was no waking member of night staff. The needs of one resident in the house had changed considerably. This resident slept on the first floor and required assistance with the stairs. A fire drill had not been conducted to demonstrate that this was an effective arrangement especially given the limitations in fire safety and the night time staffing arrangements. Inspectors were sufficiently concerned by their findings that they required immediate action to be taken by the provider in regards to the night time staffing arrangements in this house. Inspectors confirmed prior to leaving the centre that the necessary actions had occurred.

Records evidenced that fire alarms, fire blankets and fire extinguishers were serviced at regular intervals. Staff had received training in fire safety.

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:

Residents told inspectors that they felt safe in the designated centre. From the sample of training records reviewed, inspectors confirmed that staff had received training in the protection of vulnerable adults. Inspectors were informed of an allegation of abuse which had occurred in the centre. While appropriate action was taken at the time, the plans of care for those residents involved did not adequately identify the supports residents required to prevent a reoccurrence.

Residents were identified as presenting with challenging behaviour. Primarily the behaviours presented as inappropriate language or gestures. Inspectors reviewed the plans in place to support residents and found that they did not adequately guide appropriate practice. For example, daily records provided information of a resident engaging in behaviour that upset other residents. The support provided was not in line with best practice and did not demonstrate that efforts had been made to alleviate the cause of the behaviour. There was another instance in which records stated that staff had to physically intervene to support a resident. No review had been conducted following the incident. One resident reported that they had difficulty sleeping due to the behaviours of their peers. Daily records also evidenced that some residents' regularly used abusive language towards their fellow residents. This had not been addressed by the provider. Some residents engaged in self injurious behaviour. Daily records or support plans did not demonstrate that appropriate measures were in place with the aim of safeguarding residents.

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:

Residents confirmed that they had regular access to their general practitioner (GP). Records of appointments confirmed that residents were supported to attend their GP and other health care professionals. Assessments had been completed for residents using evidenced based tools. Plans of care for residents had been created based on their health care needs. The quality of the assessments and plans were inconsistent throughout the seven houses. In some instances, plans were specific and measurable. In other instances, they did not adequately identify the supports residents required.

Inspectors reviewed a sample of assessments and found that for some residents there was an absence of assessment for staff to support them with their mobility. Inspectors identified one falls assessment which had not been accurately completed and therefore the risk of falls was actually greater than the assessment indicated. As a result, plans of care did not provide the appropriate supports that residents required.

Inspectors also identified a failure by staff to put in place an end of life care plan for one resident in receipt of palliative care.

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):

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

Findings:

Inspectors reviewed the medication management systems. Medication was stored in a secure location. There was a stock check system in place however the records maintained did not always include a signature of staff. Inspectors observed that some residents were supported to be actively involved in the management of their medication with minimal support of staff. Staff were observed to engage in a dignified manner with residents when administering medication.

Inspectors reviewed a sample of prescription and administration records and found that they contained all of the necessary information. There were protocols in place for medication that was prescribed as required. However, inspectors found that in one instance, pain relief was not administered as prescribed.

Inspectors were also not assured that the measures in place for the management of control drugs were safe. A resident had been prescribed controlled drugs as required. The medication had been administered. However there was no guidance in place to inform staff on the time in which the medication could be administered. Furthermore the daily stock check had only commenced four days following the medication being received in the centre.

Judgment:

Non Compliant - Moderate

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:

The Chief Inspector had been notified that the person in charge was absent from the designated centre for more than 28 days. In the absence of the person in charge, two staff members were nominated to manage the centre. However considering the cumulative evidence gathered during this inspection and the absence of action taken following the two previous inspections, inspectors were not assured that this arrangement ensured effective governance, operational management and administration of the designated centre, especially considering the number of houses within their remit. For example, one of these staff members was responsible for the management of ten individual houses.

Inspectors found that the management structure in place did not identify specific individuals who are responsible for all areas of service provision. As identified in this report, deficits in staffing, failure to meet the changing needs of residents and the unsuitability of premises had been identified by residents, staff and frontline management. However inspectors were unable to determine who in the organisation was responsible for addressing these issues.

Inspectors also found that the management systems in place did not promote a safe and effective service. There were limited reviews of the quality and safety of care conducted. Of the reviews completed, inspectors found that they did not address all relevant areas

of service provision to ensure that the service was safe. Significant areas of risk identified by inspectors had not been identified by the provider.

Inspectors reviewed a sample of the reviews and found that they did not adequately identify all factors. For example, in one house the reviews stated that all staff training records were up to date. Inspectors reviewed the records and identified gaps. Six monthly unannounced visits had not been carried out and an annual review into the quality and safety of care as required by the regulations had not been completed. The reviews/visits carried out in the centre did not meet the requirements of the regulations. They concentrated on documentary issues and did not identify issues such as premises, risk management and safeguarding.

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 met with staff and found that they spoke warmly about the residents. Resident consulted spoke positively about staff and were complimentary on how well they were looked after. Notwithstanding, inspectors identified that there was insufficient staff employed in the designated centre. Furthermore due to the changing needs of residents, the skill mix was not appropriate to meet the needs of residents.

Inspectors were informed by residents that there was insufficient staff which prevented them from partaking in activities in line with their interests. Daily records demonstrated that when residents left the centre it was for group activities. If a resident chose not to go, they had to go to another house either in the centre or another centre. There was one situation in which a resident became unwell while in day service. They had to go to another house as there was no staff in their house until later that day. A resident had logged a complaint as they wanted to go for a walk on a Wednesday however there was no staff to support. The resolution was that the resident agreed to go for a walk on Friday.

Inspectors observed and records confirmed that residents had to wait for support for personal care on a regular basis due to staffing levels. In one house, the roster indicated and observation confirmed that three staff were on duty (two care staff and one staff nurse) from 08.00 to 00.00 hours. However the staff nurse also had responsibility to support other houses. Records confirmed that they were regularly absent from the house. Two residents each required support from two staff. This meant that when the staff nurse was absent and one of these residents required care, the other seven residents were left unsupervised.

Inspectors were told by management that a review of staffing will occur in June 2016. However, this need had been identified on the two previous inspections, and the provider had previously stated that it would occur in October 2015.

Inspectors were not assured that staff had the appropriate skills and training to support residents' changing needs. Staff had not received training in dementia care. Inspectors observed deficits in the plans of care and found that the needs of residents diagnosed with dementia were not being met. Staff also had not received training in CPR.

In one house, residents were prescribed medication as required for the management of seizure activity. The protocol was for the medication to be administered two minutes following the seizure commencing. Staff in the house did not have training in the emergency administration of anticonvulsant medication. The procedure was for staff in the neighbouring house to attend. This had not been assessed to ascertain the feasibility of this practice. Some staff did not have manual handling training.

Inspectors were informed that formal staff supervision was due to commence. Notwithstanding this, inspectors were not assured that the appropriate informal supervision was occurring. Inspectors observed that staff were not completing daily records of the care provided to residents. This had not been identified by persons participating in the management of the centre. Due to the number of houses within front line management's responsibility, inspectors were not assured that they attended the houses on a sufficiently regular basis to supervise staff. Inspectors were also informed that the manager of one of the houses had no managerial responsibility for some staff working in the house.

There was one volunteer in the centre and inspectors confirmed that all necessary documents was in place as required by the regulations.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Jillian Connolly
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 report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005331
Date of Inspection:	11 May 2016
Date of response:	17 June 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Residents were admitted to the centre in the absence of appropriate criteria.

1. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

accordance with the statement of purpose.

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

- All admissions to designated centres will be fully transparent and in accordance with the Designated Centre's Statement of Purpose.
- Compatibility assessments and transition plans will be prepared in consultation with the resident and their family/carer. All current residents have the required assessments and transition plans in place. Completed Responsible Person: Person in Charge

Proposed Timescale: 17/06/2016

Theme: Effective Services

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

Residents were not provided with the opportunity to visit the centre prior to being admitted.

2. Action Required:

Under Regulation 24 (2) you are required to: Provide each prospective resident and his or her family or representative with an opportunity to visit the designated centre, insofar as is reasonably practicable, before admission of the prospective resident to the designated centre.

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

- All prospective residents, their family/carer or representative will be provided with an opportunity to visit the designated centre before admission.
- Person Responsible: Person in Charge from current centre and receiving centre.

Proposed Timescale: 17/06/2016

Theme: Effective Services

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

Written agreements were not signed.

3. Action Required:

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

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

- On admission an agreement in writing outlining the terms on which the resident will reside in the designated centre will be signed by the resident or their representative where the resident is not capable of giving consent
- Person Responsible: Person in Charge

Proposed Timescale: 17/06/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Residents did not receive a comprehensive assessment prior to admission.

4. Action Required:

Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

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

- A comprehensive assessment of the health, personal and social care needs will be undertaken by an appropriate health care professional for each resident prior to admission to the designated centre or transitioning to another designated centre.

Persons Responsible: Multidisciplinary Team and Person in Charge

Proposed Timescale: 17/06/2016

Theme: Effective Services

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

Assessments were not comprehensively reviewed following a change in need.

5. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

- A comprehensive assessment will be undertaken by an appropriate health care professional, of the health, personal and social care needs of each resident at least annually or following a change in the residents needs, circumstances or when recommendations are made by a member of the Multidisciplinary Team. All annual reviews for all residents will be completed by Oct 31st 2016.

Persons Responsible: Multidisciplinary Team and Person in Charge

- All nursing assessments have been reviewed and updated as appropriate Completed 17th June 2016. Person Responsible: Person In Charge

- An annual schedule of MDT reviews has been developed for the service.

Person Responsible: Person In Charge

- An audit of a representative sample of care plans has commenced within the service. This will be completed by 29th July 2016. Audit findings will be presented back to the

PIC and addressed accordingly. Persons Responsible: Person in Charge

Proposed Timescale: 31/10/2016

Theme: Effective Services

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

Personal plans were not reviewed following a change in need.

6. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

- All residents' personal plans will be reviewed annually or more frequently if there is a change in needs or circumstances or if there are recommendations made by a member of the Multidisciplinary Team. Completed June 17th July 2016

Persons Responsible: Multidisciplinary Team and Person in Charge

- Resident's personal goals will be evaluated on a monthly basis. Evaluated on June 17th July 2016 with monthly reviews hereafter.

Persons Responsible: Person in Charge

- An audit of a representative sample of person centered plans has commenced within the service. This will be completed by 29th July 2016 with implementation of Audit Findings.

Persons Responsible: Person in Charge

Proposed Timescale: 31/07/2016

Theme: Effective Services

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

Personal plans did not adequately identify the supports residents required to maximise their development.

7. Action Required:

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

- A personal plan will be developed for all residents no later than 28 days after admission to their home within the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes. Persons Responsible: Multidisciplinary Team and Person in Charge

- Each resident will be assigned a named nurse or key worker to actively engage with the resident and their family representative to develop a holistic plan of care. Person Responsible: Person in Charge
- All current residents have an up-to-date personal plan in place. Completed June 17th 2016 Person Responsible: Person in Charge

Proposed Timescale: 17/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The houses were not meeting the needs of all residents residing in them.

8. Action Required:

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

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

- A review has been undertaken of the designated centre to encompass the required supports of the residents and provide the most appropriate premises to meet their needs. Person Responsible: Provider
- Individual independent living accommodation has been secured for 1 resident. This resident will transition 21st July 2016 to this more suitable accommodation. Person Responsible: Person in Charge
- An apartment has been secured for 1 resident and will be ready for occupying 31st Oct 2016. Person Responsible: Provider
- The process has commenced to secure an alternative provider for 1 resident. An assessment by this provider will be conducted by End of September 2016. Person Responsible: Provider
- 4 residents will transition to more appropriate accommodation. This accommodation has been sourced and upgrade works planned. The transition for 4 residents will be complete by End September 2016. Person Responsible: Person in Charge
- 3 residents will relocate to a nearby more appropriate accommodation. 31st Oct 2016 Person Responsible: Person in Charge
- 1 resident who has specific dementia related needs will transfer to more appropriate accommodation 31st Oct 2016. Person Responsible: Person in Charge
- 5 Residents living independently in 1 house have met with their advocate from NAS to seek alternative housing option with their own tenancy agreement. A viewing of a house is underway with the input from PCCC OT Department. The nominated advocate on the ladies behalf has advised that all decisions pertaining to the residents involved are respected and that they will submit their own self-directed will and preference on where and with whom they live. A more detailed sheet with client identifiers will be sent independently to HIQA which will show the exact client movement between the different house. Person Responsible: Provider

Proposed Timescale: 31/10/2016

Theme: Effective Services

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

Parts of the designated centre were not in a good state of repair.

9. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

- A schedule of maintenance requirements has been developed and work has commenced on addressing the identified repairs required. Person Responsible: Provider in conjunction with HSE Estates Department
- Damaged floor covering identified in dining/kitchen area has been replaced as of 6/6/16. Person Responsible: Person in Charge
- Windows requiring painting have been steam hosed and painted as of 16/6/16. Person Responsible: Person in Charge
- External areas have been steam hosed and tidied. 16/06/16 Person Responsible: Person in Charge
- Garden furniture and floral arrangements are provided in external accessible areas for residents. All gardens have been mowed and this will continue on a monthly basis. Person Responsible: Person in Charge

Proposed Timescale: 16/06/2016

Theme: Effective Services

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

Parts of the centre were not clean.

10. Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

- Industrial cleaners have undertaken a deep clean in the identified area. Completed 23/05/16. Person Responsible: Person in Charge
- A monthly schedule of deep cleans have been arranged for the designated centre to ensure all houses are maintained in a clean state. Person Responsible: Person in Charge

Proposed Timescale: 23/05/2016

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 systems in place were not effective.

11. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

- The PIC has completed a full review of all risk management systems in each house to reflect how the designated centre responds to emergencies as and when they occur. The system will ensure that control measures are implemented.
- The Estates Department has undertaken a review of houses within the designated centre and all houses with immediate risks related to environmental factors have been immediately acted upon.
- The maintenance department have completed a schedule of work to install safety measures on upstairs windows and exit doors, completed 16/6/16.
- Hand rails where required will be installed as a matter of priority, Voluntary housing association has been contacted to provide these.. This will be followed up by the provider at a scheduled meeting with the Voluntary Housing Association... Person Responsible: Provider

- Thumb turn locks have been installed on all external exit doors to ensure exits are accessible in the event of an emergency and evacuation. This has been completed on 16/6/16. Person Responsible: Person in Charge
- Planned fire evacuations have been undertaken in all houses in the designated centre and will continue on a monthly basis. Fire management systems have been reviewed by staff conducting the evacuation within the designated centre to demonstrate that all residents can be evacuated with the least number of staff on duty within an appropriate timeframe.
- An assessment of residents who are on occasions unsupervised has been conducted to ensure they can evacuate safely within an appropriate time frame in the event of an unplanned emergency. Evacuations will continue on a regular basis. Person Responsible: Person in Charge
- Medication management systems have been reviewed to ensure safety and full compliance with the Medication Management Policy and best practice. Person Responsible: Person in Charge
- A risk assessment has been completed on the possible risk of residents' leaving without knowledge of staff from the designated centre; This is recorded in the Risk Register. Person Responsible: Person in Charge
- There is a staff training schedule currently in place to address deficits identified. Staff training will be provided for staff in line with residents identified needs i.e. CPR, Dementia, Safe Administration of Medications and First Aid as appropriate. Person Responsible: Person in Charge
- Deep cleans have been undertaken within the designated centre in a prioritised manner. A schedule has been developed for ongoing monthly cleaning arrangements

within the service. Person Responsible: Person in Charge

- A review of staffing will be undertaken within the service by an independent source.

Person Responsible: Provider

- The issue of staff lone working for entire weekends has been minimised as far as possible, this now only impacts on 1 house. A risk assessment has been undertaken and controls have been identified to minimise this i.e. an agreed communication strategy that clearly identifies contact persons over a 24 hour period. This issue will also be considered within the remit of the upcoming staffing review within the service; dates of July 19th and 21st have been identified to commence this process. Person Responsible: Provider

- The vet has been contacted as to the care and management of the household pets who present as hygiene concerns to all residents living in this house. A dialogue has taken place and a good outcome has been achieved for the resident and their pet.

Person Responsible: Person in Charge

- An unannounced visit has been completed by the Nominee Provider and the Director of Services since 13th May 2016 and also on the week of 13th June 2016.

Proposed Timescale: 16/06/2016

Theme: Effective Services

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

The fire management systems in place were ineffective and did not include the environmental, clinical and operational factors relevant to the centre and the needs of the residents.

12. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

- Arrangements have been made to have all community group homes assessed by the Estates Department in relation to works to replace and upgrade fire doors and the installation of active life safety systems i.e. emergency lighting.
- The Maintenance Department have installed
(1) thumb turn locks on external exits doors and
(2) Restrictors on upstairs windows as appropriate within the designated centre. Both completed 16/6/16 Person Responsible: Person in Charge
- The use of wedges has been eliminated throughout the designated centre as of 13/5/16. Person Responsible: Person in Charge
- Planned fire evacuations have been undertaken at times when residents are at their most vulnerable and plans are under review to ensure they reflect the actual circumstances which include the supports required by residents with the minimal staff on duty. These have occurred 13th, 25th & 31st May, 10th & 16th June and 8th & 10th July 2016 and will continue on a regular basis. Person Responsible: Person in Charge
- An observed unsupported evacuation has been conducted on 13th May & 10th June 2016 & 8th July 2016 with residents who are in instances unsupervised by staff to

assess their ability to evacuate safely in the event of an emergency. Person Responsible: Person in Charge

- A easy read information sheet is available for residents regarding fire safety and evacuation and safety. Person Responsible: Person in Charge

Proposed Timescale: 17/06/2016

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:

Residents were not effectively supported to identify the cause of their inappropriate behaviour.

13. 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:

- A review of the positive behaviour support plans has been undertaken to ensure that the identification of the cause of the inappropriate behaviour has been identified and alternative measures have been established to ensure that the least restrictive procedure, for the shortest duration necessary, is used to reduce the likelihood of reoccurrences; this will be kept under review by the CNS in behaviours for effectiveness.
- The support of the psychology department has been secured for all residents to review the use of restrictive procedures.

Proposed Timescale: 17/06/2016

Theme: Safe Services

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

Residents were not protected from inappropriate verbal language and gestures displayed by their fellow residents.

14. Action Required:

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

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

- Safeguarding screening has been completed and a plan developed to ensure all residents are protected. This has been forwarded to the national safeguarding team as per policy. Person Responsible: Person in Charge
- Suitable accessible accommodation has been identified for one resident in this house; the accommodation is presently undergoing work to ensure all facilities are accessible and appropriate for the resident. Accommodation is expected to be available by end of October 2016. Person Responsible: Provider
- The behaviour support plan has been reviewed and updated to ensure techniques for distraction and deflection of inappropriate behaviours are appropriate and employed by support staff. Action completed by 30th May 2016 Person Responsible: Clinical Nurse Specialist
- Compatibility assessments have been undertaken and transition plans commenced for the smooth transition of the resident when new accommodation becomes available. The Resident and family will be provided with an opportunity to visit the identified accommodation when it becomes available Person Responsible: Person in Charge
- Through consultation with the second resident, a transition plan has been developed with identified supports in place, to transition the resident to a more suitable accommodation The resident has a planned holiday with family abroad from June 30th to July 18th. This transition process will continue with the resident moving to their new accommodation on 21/7/16. Person Responsible: Person in Charge
- The process has commenced to secure an alternative provider for 1 remaining resident. An assessment by this provider will be conducted by End of September 2016 Person Responsible: Provider
- A transition plan has been commenced for the remaining resident. When suitable accommodation becomes available to meet the resident's needs the transition plan will be updated to support the resident in this process. The Resident and family will be provided with an opportunity to visit the identified accommodation when it becomes available. Person Responsible: Person in Charge

Proposed Timescale: 31/10/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Assessments and plans of care did not ensure that residents health care needs are met.

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:

- A Care Plan audit schedule has been developed to improve the assessment of residents' health care needs within the designated centre. Documented audits will be undertaken on a regular basis by clinical nurse managers and staff nurses to ensure that residents' needs are identified and supports and interventions are put in place to

address their needs. July 31st 2016 Person Responsible: Person in Charge

- A care planning group chaired by the practice development coordinator has been established to support staff to improve the care planning process within the service. Person Responsible: Provider
- An audit of mobility assessments has been completed to ensure all residents who require supports with their mobility will receive appropriate interventions to address this. Action completed on 31st May 2016. Persons Responsible: Multidisciplinary Team and Person in Charge
- A falls assessment on one resident has been repeated and the care plan now identifies the appropriate supports that are required by the resident in relation to their risk of falls. Action completed on 31st May 2016. Persons Responsible: Multidisciplinary Team and Person in Charge
- End of Life care plans are being developed through discussion with residents, family members and the palliative care team as appropriate. Person Responsible: Person in Charge

Proposed Timescale: 31/07/2016

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:

Medication as required was not administered in line with the prescription or in the absence of appropriate guidance.

16. 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:

- Appropriate and suitable practices have been put in place in relation to the ordering, receipt, prescribing, storage, disposal and administration of medications as per prescription for each individual resident.. Guidance has been put in place in relation to the administration of controlled drugs. A controlled drugs check continues to be completed at the end of each shift which is signed by two nurses. Completed 10th May 2016. Person Responsible: Person in Charge
- Staff within the designated centre have agreed to undertake the online element of medication management training.

Proposed Timescale: 10/05/2016

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:

Inspectors found that the cumulative findings of this inspection demonstrated that the person in charge could not be the person in charge of more than one designated centre.

17. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

- A full review of the PIC role has been completed and as a result approval has been provided to assign an additional suitable qualified person to take up the role of PIC. An expression of interest has been circulated within the wider Learning Disability Service for the position of PIC. Interviews due to be completed by Aug 5th 2016. Person Responsible: Provider
- A PIC will be appointed from this campaign to have responsibility for only this designated centre and will ensure the effective governance, operational management and administration of the designated centre concerned. Person Responsible: Provider
- The Nominee provider has met with the management team on a number of occasions regarding effective governance in practice. Staff will be redeployed where required.. Person Responsible: Provider

Proposed Timescale: 01/09/2016

Theme: Leadership, Governance and Management

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

Management structures did not identify the individuals responsible for all areas of service provision.

18. Action Required:

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

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

- A review of the management structures within the designated centre has been undertaken to ensure that a clearly defined management structure is in place that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. Action completed 29th June 2016

Person Responsible: Provider

- A recruitment process is underway to select a PIC to lead out on the necessary changes required as stated pursuant to all aspects of regulation 23 Person Responsible: Provider

Proposed Timescale: 01/09/2016

Theme: Leadership, Governance and Management

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

The systems in place to ensure the quality and safety of care provided to residents were not effective.

19. 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:

- The newly developed HIQA template for assessing the quality and safety of care annual report will be used to assess the performance against national standards. Audits are being completed which will be used in the report to evidence the quality and safety of care within the designated centre. Person Responsible: Person in Charge
- Unannounced quality and safety walkabouts will continue in this service. Person Responsible: Provider and Director of Service
- A Governance & Management report has been compiled and will be forwarded to the Authority by 13th July 2016 Person Responsible: Provider

Proposed Timescale: 01/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

There were insufficient staff employed in the centre.

20. 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:

- An independent external staffing review of the designated centre will commence on July 19th and 21st to ensure there are sufficient numbers of staff with the appropriate

qualifications to meet the assessed needs of the residents. This review process will take a 4 week timeframe from initiation to conclusion. Person Responsible: Provider

- Mandatory Training will be completed by all staff. A schedule of training will be developed to address all mandatory training. 100% of staff has completed Safeguarding training. 100% of staff will have completed Fire Management training by 22nd July 2016. Dementia training has taken place on June 15th & 29th 2016.
- A care plan review of the service has been commenced as of Monday 13th June to assess the required needs of the residents living there. This will of the review will be implemented accordingly. completed by July 31st 2016 Person Responsible: Person in Charge

Proposed Timescale: 31/08/2016

Theme: Responsive Workforce

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

Staff were not appropriately supervised.

21. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

- A schedule of supervision has been developed for all grades of staff within the designated centre. A supervision meeting will be held with individual staff members in line with their role and responsibilities. A supervision agreement meeting has been conducted with managers within the designated centre as of the end of May 2016. Person Responsible: Provide & Person in Charge

Proposed Timescale: 17/06/2016

Theme: Responsive Workforce

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

Staff were not provided with the appropriate training to meet the changing needs of residents.

22. 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:

- A rolling schedule has been developed to ensure that staff will be provided with all appropriate training including refresher training as part of their continuous professional

development and in line with the needs of residents within the designated centre.
Training will focus initially on dementia care (commenced 15/6/16), epilepsy and CPR.
Person Responsible: Provider

Proposed Timescale: 17/06/2016