Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Chapel View
Centre ID:	OSV-0001931
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Shane Kenny
Lead inspector:	Jillian Connolly
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	10
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 1 day(s).

The inspection took place over the following dates and times

From:	To:
18 July 2017 10:00	18 July 2017 20:00

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

Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the fifth inspection of the centre. Since May 2016, there has been ongoing engagement between HIQA and the provider regarding the safety and quality of care provided to the residents of Chapel View. There had been inspections completed in May 2016 and January 2017. Both inspections identified significant failings of regulation. The provider had submitted a governance plan to HIQA which included actions that would be taken to improve services to this and other centres that they operate. The provider had also submitted a specific action plan for this centre. The purpose of this inspection was to identify if the appropriate action had been taken and was improving the lives of the residents.

How we gathered our evidence:
As part of this inspection, inspectors met six residents. Inspectors also met staff, observed practices and reviewed documentation such as residents' personal plans, health and safety documentation and audits. Residents, management and staff facilitated the inspection.

Description of the service:
The centre is one house located in Co. Kildare. The centre is registered for individuals over the age of 18. All residents were male. The centre is operated by Nua Healthcare.

Overall findings:

Inspectors found that there had been an improvement in staff knowledge of residents' assessed needs since the last inspection. Additional support had been provided regarding supporting residents' healthcare needs and positive behavior support. Staff also spoke to inspectors about positive initiatives which were occurring including holidays for residents and opportunities for community engagement. The provider had also commenced trending accidents and incidents in the centre. There had been a reduction in the frequency that physical restraint had been used and in the number of adverse events. However, inspectors found that safeguarding and risk management systems did not adequately safeguard residents or staff.

Actions arising from audits had not been addressed. The information captured in the new trending system was not reflective of the actual risk within the centre. Fundamentally, inspectors determined that residents were not adequately protected from violence of any form due to the incompatibility of residents who required high supports as a result of high risk complex needs. The centre is home to 10 individuals and at times during the day there are 13 staff on site. The combination of 23 individuals in one centre did not reflect a homely environment which promoted a safe and effective service. A number of failings which were first identified in May 2016 and again in January 2017 are repeated in this report.

Within this report, the inspection findings are presented under the relevant outcome. The action plan at the end of the report sets out the failings identified during the inspection and the actions required by the provider to comply with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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 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 work had commenced to develop the systems in place for the assessment and management of risk. However, not all actions had been completed within the time frame identified by the provider. While there had been a reduction in the number of adverse events within the centre; inspectors found that incidents were still occurring which placed residents and staff at risk. Risk management policies and procedures were not consistently implemented in response to these incidents. For example, reviews of incidents did not identify if the control measures in place had been implemented and were effective. Therefore the provider had not demonstrated that all efforts were being made to promote the safety of the individuals living and working in the centre.

The provider had stated that a summary risk document would be introduced to the centre by the end of June 2017. The purpose of which was to strengthen the oversight of the actual risk in the centre. This was not available as of the day of inspection. However, it was provided to inspectors one month after the inspection. Inspectors reviewed the document and found that while it addressed some of the risks in the centre, it did not adequately account for all of the risks within the centre. Inspectors found that insufficient action had been taken to ensure that the risk associated with individual residents was appropriately assessed and adequately reviewed following adverse events. For example, a high risk of physical aggression had been identified. Incidents had occurred confirming the risk was high. It had been identified by a psychiatrist that these violent outbursts were occurring with mainly female staff. Inspectors reviewed incidents in which female staff were on their own and had been assaulted. This risk had also been identified by inspectors and communicated to the provider in January 2017.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Inspectors found that there had been a significant reduction in the use of physical restraint and psychotropic medication in response to behaviours that challenge. Notwithstanding this, inspectors found that individuals were not adequately safeguarded in the centre, primarily due to the number and compatibility of residents residing together, and their individual needs. Inspectors found that while allegations and suspicions of abuse were identified and reported through policy. The subsequent safeguarding plans which were developed did not address the fundamental risk of certain residents living together.

HIQA had been informed of a number of allegations or suspicions of abuse. Examples included residents being verbally abusive towards each other, being spat at, entering each other's bedrooms and residents threatening to hit other residents. Safeguarding plans had been developed which included measures such as staff supervision, resident's being given the opportunity to make a complaint and reviews by allied health professionals for the person causing concern. Staff stated that they endeavour to keep people safe and are aware of which residents should not be in a communal area at the same time. Staff further stated that they were vigilant and will intervene to safeguard residents. However, inspectors determined that residents were not living in a safe environment.

Inspectors found that staff were more informed about the necessity of positive behaviour support and the implementation of proactive strategies on this inspection. Staff were of the view that this increase in knowledge contributed towards the reduction of physical restraint and incidents in the centre. The provider had also allocated an allied health professional to the centre for one day a week who had the responsibility for oversight of positive behaviour support. There had been an increase in incidents of aggression in the centre as a result of a change in need for one resident. Inspectors found that this had been identified by the provider in their monthly assurance reports and additional staffing had been allocated. However, there had been an undue delay in referral to and assessment by the appropriate allied health professionals. Inspectors also

found that when physical restraint was used, it was not comprehensively reviewed to ensure that it was the least restrictive option available and that it was used for the shortest period of time.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Following the last inspection, the provider had allocated a nurse to the centre to monitor all residents' healthcare needs. This had been increased to two nurses two weeks prior to the inspection occurring. Staff were very positive about the provision of clinical staff on site. Inspectors also noted that this was evident in the care provided to some residents. However, inspectors found that additional improvement was required to ensure that personal plans contained the appropriate assessments and supports that residents' required. Records of the day to day care provided to residents did not consistently demonstrate that residents were supported in line with their personal plans.

Residents were supported to attend their General Practitioner (GP) if a need arose. They were also supported to attend healthcare appointments with allied health professionals. Health management plans had been developed for residents. The nursing staff had commenced delivering training in areas such as dysphasia, blood pressure and recording of monitoring.

Inspectors found that some of the information in residents' personal plans conflicted with the care provided. For example, the times in which residents should have their blood sugars monitored. In one instance, there were four plans in place for diabetes care, three of which stated that a resident did not have diabetes and one stating that they did have a diagnosis of diabetes. Staff confirmed that the resident had a diagnosis of diabetes and outlined to inspectors the care to be provided.

Daily records did not consistently demonstrate that residents were supported in line with their needs. For example, the records for one resident indicated that they had not eaten from 14.00 hours to 08.30 hours the next morning. Staff assured inspectors that this was a recording deficit as opposed to an absence of appropriate care being provided. There was also an absence of care plans in place in relation to dementia care, resulting

in an absence of necessary supports.

Inspectors did note that there had been a significant improvement in the care provided to residents who had a history of pressure sores.

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:
Following the last inspection, HIQA have had extensive engagement with the provider regarding the quality and safety of care provided to residents. This included the submission of a governance plan. Inspectors acknowledged that the provider had demonstrated a willingness to improve the services provided. Notwithstanding this, inspectors found that due to the safeguarding concerns and risk management systems employed on a day to day basis, there remained deficits in the systems in place for ensuring that the service was safe and effective.

A variety of tools had been developed including trending of accidents and incidents. This information was provided to inspectors and identified that there had been a significant decrease in the number of adverse events in the centre. However, inspectors found that this information was not accurate, therefore undermining the validity of the information. For example, inspectors found that not all instances of physical restraint had been captured in the trend analysis. Inspectors were also provided with information that stated there had been only 4 assaults on staff since the last inspection. During the course of the inspection, inspectors identified additional assaults on staff which had not reflected in the data provided to inspectors. Inspectors communicated this at the closing meeting and were informed that the provider was in the process of rolling out a new online Accident/ Incident Reporting System across the service. The aim of which was to prevent such errors occurring in the future.

Inspectors also reviewed a sample of audits which had occurred since the last

inspection. They included an audit of personal plans, restrictive practices, record keeping and complaints. While deficits were identified through these audits, inspectors found that they were not adequately acted on. For example, audits identified that risks assessments were not exhaustive and did not identify all control measures. This was identified in May 2017, and as evidenced in this report had yet to be addressed.

Management confirmed that there remained an absence of a report which was due to be generated from an unannounced visit by the provider. However, they stated that they were aware of the requirement for this and it was a work in progress.

There had also been no annual review of the quality and safety of care completed.

Fundamentally inspectors found that while work had commenced in the six months since the last inspection, including an increase in nursing staff, there remained a number of repeated failings of regulation which directly affected the safety and quality of care provided to residents. The action plan submitted had also not been completed in the stated timeframe.

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 observed practice and found that staff engaged with residents in a dignified and respectful manner. However, inspectors found that staff resources were not organised in a way to meet the assessed needs of residents.

Inspectors were provided with the hours that each resident was due to be provided with individual supports i.e. the support of one or two members of staff. Inspectors reviewed this information with staff and found that the assessments of residents' needs differed from this information. For example, one resident was assessed as requiring two staff at all times and a second resident was assessed as requiring one staff. On arrival to the centre inspectors observed both residents to be outside with the support of one staff

between them. There were ten staff on duty at this time. The inspector observed due to the number of residents being supported with personal care or out of the centre, there was not enough staff available at that time to provide the support required. Staff confirmed to inspectors that this can be a challenge. The provision of high staffing was identified as a safeguarding measure in response to allegations and suspicions of abuse.

This had previously been raised with the provider who had stated that there was sufficient staff on the roster at all times. However, the organisation of these staff had not been reviewed since the last inspection.

Staff had been provided with mandatory training. Additional support had been provided to staff regarding healthcare and positive behaviour support. Staff spoke positively about the additional training they were receiving and stated that it had a positive impact on the support provided to residents.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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 report[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0001931
Date of Inspection:	18 July 2017
Date of response:	21 August 2017

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 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 and management of risk were not implemented effectively.

1. Action Required:

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

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

Please state the actions you have taken or are planning to take:
1.Review of all Control measures currently in place for Risk Assessments [Due date: 08 September 2017].
2.Current Risk Management System is under review as part of the Governance Plan and new system will be rolled out in the Centre [Due date: 31 October 2017].
3.Resident identified by the inspector to be staffed with male staff while a scheduled assessment of need is to be complete in consultation with internal and external MDT. Staffing requirements will be reviewed following assessment [Due date: 25 September 2017].
4.Training on Risk Management to be provided for to all staff in the Centre [Due date: 25 September 2017].
5.Behavioural Specialist to be placed in the Centre for 3 days a week and specific Key Task List to be developed identifying key areas to be worked on within the Centre which will be reviewed regularly. The Key Tasks are as follows;
- Review Incidents, Safeguarding and Behaviours that challenge
- Review Restrictive Practice Register
- Review Risk Assessments/SOP and amended in consultation with the PIC
- Review Behavioural Support Plans and Reactive Strategies
- On Site Supervision of modelling Positive Behavioural Support Plans

[Due date: Week beginning 21 August 2017].
6.New PIC starting in the Centre on the 21st and will receive complete handover within the Centre. Relevant documentation to be sent to the Authority for approval [Due date: 25 August 2017].
7.The PIC is to oversee all actions been complete in the Centre on a daily basis [Due date: Immediate]
8.New Regional Manager to be in the Centre weekly to ensure action plan is complete [Due date: Week beginning 21 August 2017].
9.Director of Services to have daily check-in's with the clinical team in the Centre. The DOS to be in the Centre monthly to ensure oversight in the Centre [Due date: Week beginning 21 August 2017].

Proposed Timescale: 31/10/2017

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 consistently supported to identify and alleviate the cause of their behavior.

2. 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:
1 .Behavioural Specialist to be placed in the Centre for 3 days a week and specific Key Task List to be developed identifying key areas to be worked on within the Centre which will be reviewed regularly. The Key Tasks are as follows;
· Review Incidents, Safeguarding and Behaviours that challenge
· Review Restrictive Practice Register
· Review Risk Assessments/SOP and amended in consultation with the PIC
· Review Behavioural Support Plans and Reactive Strategies
· On Site Supervision of modelling Positive Behavioural Support Plans and Restrictive Practice debrief to be given to all staff.
[Due date: Week beginning 21 August 2017].
2. Restrictive Practice register to be implemented in the Centre and reviewed regularly by the PIC and clinical team assigned to the Centre [Due date: 25 September 2017].
3. Review of behavioural support plans and reactive strategies to be complete by the Clinical Team [Due date: 20 October 2017].
4. Positive Behavioural Support Training to be provided at all staff at the team meetings on the 31 Aug, 14 Sept and 28 Sept [Due date: 28 September 2017].
5 .New PIC starting in the Centre on the 21st and will receive complete handover within the Centre. Relevant documentation to be sent to the Authority for approval [Due date: 25 August 2017].
6. The PIC is to oversee all actions been complete in the Centre on a daily basis [Due date: Immediate]

Proposed Timescale: 20/10/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of incidents did not demonstrate that the use of physical restraint was the least restrictive practice and used for the shortest duration of time.

3. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
1.Behavioural Specialist to be placed in the Centre for 3 days a week and specific Key Task List to be developed identifying key areas to be worked on within the Centre which will be reviewed regularly. The Key Tasks are as follows;
· Review Incidents, Safeguarding and Behaviours that challenge
· Review Restrictive Practice Register
· Review Risk Assessments/SOP and amended in consultation with the PIC

· Review Behavioural Support Plans and Reactive Strategies
· On Site Supervision of modelling Positive Behavioural Support Plans and Restrictive Practice debrief to be given to all staff.
[Due date: week beginning 21 August 2017].
2.Restrictive Practice register to be implemented in the Centre and reviewed regularly by the PIC and clinical team assigned to the Centre [Due date: 25 September 2017].
3.Restrictive Practice training to be rolled out to all staff at the team meetings on the 31 Aug, 14 Sept and 28 Sept [Due date: 28 September 2017].
4.The PIC and Behavioural Specialist to debrief all staff on restrictive practice with the Centre [Due date: 28 September 2017].

Proposed Timescale: 28/09/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Safeguarding plans which were developed did not address the fundamental risk of certain residents living together

4. 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:
1.Review all live safeguarding plans in the Centre with a view of ensuring they take account of the assessed needs of all residents [Due date: 25 September 2017].

2.Review the current mix of residents in the Centre. Impact assessments to be complete on all residents in the Centre [Due date: 25 September 2017].

3.Resident ID096 has been identified as discharge from the Centre. This is being done in consultation with all representatives. The PIC will communicate with the HSE on a weekly basis to identify an alternative placement for resident ID096. This will also be reviewed weekly at the ADT meeting [Due date: On identifying suitable placement].

Proposed Timescale: 25/09/2017

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 personal plans contained the appropriate assessments and supports that residents' required. Records of the day to day care provided to residents did not consistently demonstrate that residents were supported in line with their personal plans.

5. 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:
1.Review of personal plan for residents with specific health management plans identified as having dementia [Due date: 22 September 2017].

2.Refresher Specific Dementia Training to be provided at all staff at the team meetings on the 31 Aug, 14 Sept and 28 Sept [Due date: 28 September 2017].

Proposed Timescale: 28/09/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place for ensuring that the service was safe and effective did not safeguard residents and address the risk in the centre.

6. 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:
1.Review all live safeguarding plans in the Centre with a view of ensuring they take account of the assessed needs of all residents. [Due date: 25 September 2017].

2.Review the current mix of residents in the Centre. Updated Impact assessments to be complete on all residents in the Centre [Due date: 25 September 2017].

3.Resident ID096 has been identified as discharge from the Centre. This is been done in consultation with all representatives. This will be reviewed weekly at the ADT meeting [Due date: On identifying suitable placement].

4.Trend analyse to be reviewed to ensure it is capturing all information [Due date: 08 September 2017].

5.Behavioural Specialist to be placed in the Centre for 3 days a week and specific Key Task List to be developed identifying key areas to be worked on within the Centre which will be reviewed regularly [Due date: 22 August 2017]

Proposed Timescale: 25/08/2017

Theme: Leadership, Governance and Management

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

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

Please state the actions you have taken or are planning to take:
1.The annual report to be finalised and made available in the Centre to all stakeholders [Due date: 31 August 2017].

Proposed Timescale: 31/08/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There remained an absence of a report which was due to be generated from an unannounced visit by the provider

8. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
1.The 6-month unannounced visit report to be finalised and made available in the Centre to all stakeholders [Due date: 31 August 2017].

Proposed Timescale: 31/08/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that the organization of staffing resources differed from the assessed needs of residents.

9. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
1.Review of rosters to take place to ensure the allocated resources of staffing are utilised correctly within Centre. [Due date: 25 August 2017].

2.Review of the residents assessed needs to take place to ensure they are receiving the correct staffing resources [Due date: 25 August 2017].

3.Supervision Levels to be discussed with at all staff at the team meetings on the 31 Aug, 14 Sept and 28 Sept [Due date: 28 September 2017].

4.All staff to be debriefed on supervision levels in the Centre at all times [Due date: 23 August 2017].

5.New PIC starting in the Centre on the 21st and will receive complete handover within the Centre. Relevant documentation to be sent to the Authority for approval [Due date: 25 August 2017].

6.The PIC is to oversee all actions been complete in the Centre on a daily basis [Due date: Immediate]

7.New Regional Manager to be in the Centre weekly to ensure action plan is complete [Due date: Week beginning 21 August 2017].

8.Director of Services to have daily check-in’s with the clinical team in the Centre. The DOS to be in the Centre bi- monthly to ensure oversight in the Centre [Due date: Week beginning 21 August 2017].

Proposed Timescale: 28/09/2017