

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	No.3 Fuchsia Drive
Centre ID:	OSV-0002300
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Southern Services
Provider Nominee:	Una Nagle
Lead inspector:	Julie Hennessy
Support inspector(s):	Cora McCarthy
Type of inspection	Announced
Number of residents on the date of inspection:	4
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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 August 2017 09:30	01 August 2017 16:30
02 August 2017 09:00	02 August 2017 15:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
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 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the second inspection of this centre carried out by the Health Information and Quality Authority (HIQA). The first inspection took place on 14 April 2014. This inspection took place in response to an application by the provider to register this centre.

How we gather our evidence:

As part of the inspection, inspectors met with residents residing in the centre, the person in charge of the centre, the social care leader and members of the staff team.

Inspectors reviewed documentation such as personal plans, healthcare plans, training records, fire safety information and risk assessments. Inspectors also reviewed questionnaires received from family members. Relatives were complimentary of staff in the centre in the questionnaires received and of the care and support their loved ones received.

Description of the service:

The centre was located in a village and approximately 25kms from Cork city. The design and layout of the centre was in line with the centre's statement of purpose. The centre was a domestic single- storey bungalow with a small garden to the front and a larger space to the rear of the house, used by residents.

The premises comprised three bedrooms for residents and a separate apartment that could accommodate one resident in their own accommodation. Community links had been developed and residents accessed services in their local community, attending the local general practitioner, dentist, bank, post office and shops. Interactions between staff and residents were supportive and appropriate. Some residents chose to show inspectors their bedrooms or apartment, which were bright and personalised.

However, significant failing at the level of major non-compliance was identified in the following areas:

- an assessment had not been completed so as ensure that the centre was appropriate to each resident's needs and there was no system in place to ensure that the review of residents plans would be multidisciplinary (outcome 5)
- the system for assessing, managing and escalating risks was not sufficiently robust and incidents had not been recorded in accordance with the service's own policy (outcome 7)
- safeguarding concerns had not been reported to the designated person and the impact of any such concerns on other residents had not been adequately assessed. Also, an understanding of how to identify, record and report safeguarding concerns was not demonstrated (outcome 8)
- the oversight arrangements of the quality and safety of care being provided were not adequate and required review (outcome 14)

Improvements were also required in relation to the management of complaints and ensuring that staffing arrangements offered meaningful choice in relation to how residents spent their leisure time.

A representative of the provider and member of the management team attended a meeting in the HIQA head office and provided reassurances that they were carrying out a review of the arrangements in place in the centre, the oversight of those arrangements and an assessment of the current situation.

Findings are detailed in the body of the report and should be read in conjunction with the actions outlined in the action plan at the end of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Overall, arrangements were in place to consult with residents and to promote residents' dignity and respect. Failings relating to the recording of complaints had previously been identified by the provider.

Residents were supported to exercise their rights and make choices about their day-to-day lives. There was evidence that residents chose whether to attend religious services, whether to vote and what type of files were kept. Details of external advocacy were provided in the centre. Details of the designated officer for any safeguarding concerns were also visibly displayed in the centre.

A user-friendly complaints procedure was visibly displayed in the centre. While the post of complaints officer was vacant at the time of the inspection, an interim arrangement was in place. A complaints log was maintained. However, safeguarding concerns had been logged in the complaints log and managed as complaints, instead of being reported as safeguarding concerns to the designated person. The provider had identified this as a gap in their systems across the service and recently introduced a new system that would more clearly separate out complaints from concerns. Other failings that relate to the oversight of what is recorded in the complaints log will be addressed under outcome 14.

Residents' dignity was respected and there were no shared bedrooms. Interactions between residents and staff were positive and appropriate. Staff knew residents well, their likes and dislikes and residents were supported to make choices using their

preferred means of communication. Residents' independence was supported and encouraged both within and outside of the centre.

A log of residents' personal possessions was maintained. Individual books were kept for each resident's monies and expenditure. Receipts were kept for any monies spent and the person in charge monitored whether entries were double-signed. There were systems in place in relation to any withdrawals with authorised persons identified to withdraw monies. Audits of balance sheets were completed on a random basis.

At the previous inspection, the provision of storage was raised as a failing. This had been reviewed since that inspection and while one bedroom was small in size, there was adequate space for clothes and personal possessions. Residents said that they were happy with their rooms and the space available to them.

Judgment:
Compliant

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

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

Findings:

Overall, staff were observed to support and encourage residents to communicate their choices, wishes and preferences. However, residents' communication needs had not been assessed by an appropriate health professional.

Where residents had communication needs, an assessment had not been completed by an appropriate health professional in relation to communication supports. Assessments completed by staff were not adequate or accurate. There was a reliance on knowing individual residents well and what they were trying to communicate in different ways. Individual residents' personal plans indicated that they could become frustrated if they were not understood and supports were not in place if this arose, particularly in the event of unfamiliar staff working in the centre.

Other communication aids were observed, for example to support residents to interact with each other in a positive way and pictures of staff on duty were displayed so that residents would know who would be supporting them that day. Staff were observed to offer and support residents to make choices, for example in relation to what time they got up, meal times, meal choice and where to go that day.

<p>Judgment: Non Compliant - Moderate</p>

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

Theme:
Individualised Supports and Care

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

Findings:
Overall, family relationships were supported and there was evidence of residents being supported to access services, facilities and events in the local community.

Residents' personal plans outlined who was important in their lives; friends, family and relations. Residents' goals included supporting visits and relationships with family members and relations. Families were welcome to visit the centre and visits home or meetings with family members were supported by staff where required. Open communication between the staff team and families about developments, changes or issues arising was evidenced. There were photographs and pictures of those who were important in residents' lives throughout the centre. At service-level, satisfaction surveys had been completed to collate the experience of families of their satisfaction with the service being provided. These surveys also informed the annual review.

Inspectors reviewed questionnaires received from family members. Feedback from families was positive and families spoke highly of the staff and management in the centre.

The centre was located in a village and accessible by car to other towns and Cork city. Residents had access to adequate transport and participated in leisure and social activities within the locality or surrounding areas. Residents who availed of a day service accessed a nearby service and there were no unreasonable commuting distances involved.

Judgment:
Compliant

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):

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

Findings:

Overall, there were systems in place to ensure that any admissions to and transfers within the service were planned. Contracts of care had been developed since the previous inspection.

There was a policy and a committee in place to oversee admissions, transfers and discharges from the centre. There had been no admissions, transfers or discharges from the centre since the previous inspection.

The inspector saw a contract in each resident's file that comprised a service agreement and was signed by the resident or their representative.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Significant failing was identified in relation to ensuring that the system in place adequately assessed residents' needs, including any changing needs, so as to ensure that adequate supports were implemented and kept under review.

Inspectors reviewed personal plans for residents residing in this centre. A document

entitled a comprehensive assessment of needs had been completed. However, while healthcare needs had been assessed by an appropriate health professional, other areas of need had not. As a result, assessments had not been completed in relation to some areas of residents' needs and the required supports were not in place. For example, residents with communication needs had been assessed as not having any communication impairment. Behaviours of concern had not triggered an assessment of the compatibility of residents in the centre or the appropriateness of day to day arrangements, including the impact of dominant personalities on others in the house. Observations by inspectors raised queries in relation to how this dynamic was being experienced by quieter residents. Also, where mobility needs had been assessed and mobility aids recommended for use by the physiotherapist, the aid was either not being used or not being used as recommended and this information had not been relayed back to the physiotherapist. Given the aging profile of residents in this centre and changing needs over the previous 12-month period, this absence of a multidisciplinary review was of particular relevance in this centre.

Other areas of need had been adequately assessed by the staff team, as they related to leisure activities, participation in the community, daily routines, home activities and money skills.

Each resident had a written person-centred document. Information was individualised and specific. Personal plans included information pertaining to individuals' likes and dislikes, people important in their lives, hobbies and interests. Residents had a personal planning meeting, supported by their keyworker, day service worker and relatives, if appropriate and at the residents request. This meeting involved a review of goals from the previous year and residents then set goals for the following year. A person was identified as being responsible for ensuring that each goal would be achieved and within what timeframe. The progress of any goal and any barriers were identified.

However, the system in place did not ensure that the review of the personal plan would be multidisciplinary. Inspectors found that the absence of a multidisciplinary review was contributing to other gaps. The absence of a review meant that a specific forum was not provided to review what was required for each resident, for example, what referrals were to be made, which clinical risk assessments or support plans were required, what information should be collated (for example; behaviour recordings and falls data) and how that information would be reviewed.

Other specific plans had been developed based on assessment of residents' support requirements. These included individualised risk management plans, intimate care plans and dietary plans.

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):

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

Findings:

Overall, the design and layout of the premises was suitable for its stated purpose. Actions from the previous inspection that pertained to the upkeep of the environment and storage of residents' possessions had been addressed.

The design and layout of the centre was in line with the centre's Statement of Purpose. The centre was a domestic single-storey house located in a village and accessible to other towns and to Cork city. There was a small garden to the front and a larger space to the rear of the house, used by residents.

Recent renovation works had been completed, including the repair of uneven garden slabs and steps had been repaired so the new external patio was now flush with the entry to the kitchen.

There was adequate private and communal space for residents. The premises comprised three bedrooms for residents and an office which doubled as a staff bedroom. A separate apartment could accommodate one resident and provided a separate bedroom with ensuite bathroom. A patio door had been installed since the previous inspection to facilitate safe egress in the event of a fire as one bedroom had previously been an inner room. Bedrooms were individualised and reflected residents' preferences. The available storage space had been reviewed since the previous inspection. While one bedroom was small in size, it met resident's current needs and the resident told inspectors that they were happy with the space and storage provided. The premises was homely, comfortable and pleasantly decorated with pictures, art work and personal photographs.

There were adequate sanitary facilities provided. The centre had a large open plan kitchen and dining space, a sitting room and an accessible bathroom. The kitchen was fitted with appropriate cooking facilities and equipment. Residents were supported to launder their own clothes if they so wished.

The centre was clean and overall well maintained. There was suitable heating, lighting and ventilation. Uneven paving had been identified at the front of the house in audits and unannounced visits with a request for repairs made. There were suitable and sufficient furnishings, fixtures and fittings.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

There were organisational policies and procedures in place for risk management, incident management, fire safety, health and safety and infection control. However, the system for assessing, managing and escalating risks was not sufficiently robust and incidents had not been recorded in accordance with the service's own policy.

A risk register was maintained in the centre, which included individualised risk assessments. While some risk assessments were up to date, others required updating to reflect whether identified actions had been completed or to reflect changes in how risks were being managed. For example, a programme whereby a resident could remain alone unsupervised in the centre for a defined period of time had been suspended for clearly outlined reasons and this was not reflected in the risk assessment. Also, individual assessments of needs had not identified whether residents required clinical risk assessments using validated tools in relation to specific areas, for example, falls and manual handling. This had also been identified on the previous inspection and was relevant given the age profile of residents in this centre. A risk assessment that identified threatening and intimidating behaviour was inadequate and this will be further discussed under outcome 8. Key risks in the centre pertaining to safeguarding of all residents from behaviours of concern by their peers had not been escalated.

Policies and procedures were in place for the recording and reporting of incidents. There was an incident reporting book in place and incidents were reviewed by the person in charge. A new incident system had been introduced in mid-2016 to ensure that incidents would not be incorrectly recorded in the complaints log and this had been effective. However, the incident book recorded six incidents between August 2016 and January 2017, which had not been recorded on the incident system in accordance with the service's own policy, so as to allow for review and follow up of these incidents. An entry in the house meeting minutes (dated 5 June 2017) also indicated a possibility of a further more recent incident that had not been recorded on an incident form.

Procedures were in place for the prevention and control of healthcare associated infections. Infection control training had been delivered to the staff team by a hand hygiene assessor. The hand hygiene assessor in turn had access to an infection control nurse about any infection control issues arising. A cleaning schedule was in place and was being maintained. Personal protective equipment was available in the centre where required. Staff demonstrated an understanding of what procedures to follow. Staff were observed to be following infection control procedures. Sharp items were correctly

disposed of and any sharps containers were safely stored. Appropriate collection arrangements were in place for the management of any sharps containers.

Fire drills had been carried out at different times and records demonstrated that residents could be safely evacuated from the centre in a timely manner. Each resident had a personal evacuation plan, which detailed the supports they required to evacuate in the event of a fire. There was an emergency plan in place for the centre that addressed foreseeable emergencies. Servicing records demonstrated that servicing of the fire alarm, fire fighting and detection equipment and fire alarms were in date.

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):

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

Findings:

Overall, significant improvement was required to ensure that the safeguarding procedures in place in the organisation were being followed, that safeguarding concerns were reported to the appropriate person and that adequate measures were in place to assess the impact of any such concerns on residents.

Residents had access to a psychiatrist and there was evidence of regular reviews as required. However, where residents displayed behaviours of concern, a comprehensive assessment was not in place that outlined the plan of care for that individual. It was not clear whether behaviours of concern were to be recorded and if so, in what format. Where a stay well plan was in place to support mental health needs, this had been devised by the house manager and had not been approved by an appropriate health professional.

As previously mentioned under outcome 7, inspectors found that safeguarding issues had previously been recorded in the complaints book and more recently, in the incident book and in minutes of resident and staff team meetings (the month prior to this inspection). Records from the complaints and incident books recorded 11 safeguarding-related issues in 11 months. The inappropriate reporting of safeguarding concerns in the

complaints log had previously been identified by the provider, who had reviewed and made changes to the system to prevent this reoccurring. However, these concerns had not been notified to the designated officer and as a result, had not been assessed whether they required notification to HIQA or any other statutory body (including the HSE safeguarding team).

Measures had been introduced to support residents who displayed behaviours of concern and this appeared to be having a positive impact. However, it was not evidenced that the impact on residents who were experiencing these behaviours had been adequately considered or whether safeguarding plans were required for these residents. Inspectors found that this was a significant breach of the regulations and at the level of major non-compliance. The representative of the provider arranged for the designated officer to visit the centre the day following the inspection to review these safeguarding concerns and provide guidance as to what other actions were required.

There were policies and procedures in place in the organisation in relation to the protection of residents' finances and personal belongings, supporting residents' during intimate care, supporting behaviours that may challenge and restrictive practices. Inspectors reviewed a sample of residents' intimate care protocols and found that they outlined the supports each resident may require while also supporting and promoting independence.

The organisation had a committee in place that reviewed requests relating to the use of restrictive practices. Any PRN (medicine taken as required) medicine was prescribed by a consultant psychiatrist and a written protocol in place, which was signed by the prescriber. Records of PRNs administered were received and reviewed by the person in charge and a community nurse and then, also reviewed by the prescriber. However, only recent records of PRNs administered were available for review in the centre as other records were kept off-site. As a result, complete records were not maintained in the centre for auditing or inspection purposes. This will be addressed under outcome 12.

Staff had received training in relation to what to do in the event of an allegation, suspicion or allegation of abuse. The person in charge had completed training in relation to managing safeguarding concerns and the house manager and another staff were trained in the area of behaviour support. However as indicated above, a satisfactory understanding of how to identify, record and report safeguarding concerns was not demonstrated.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

A record was maintained of quarterly reports that had been submitted to HIQA. However, safeguarding concerns had not been notified to the designated officer in the organisation, in accordance with the organisation's policy. As a result, it had not been assessed and determined whether or not these incidents were notifiable to HIQA under the Regulations. The provider representative committed to arranging for all incidents or reports to be reviewed and that any retrospective notifications would be made if required.

The failure to report safeguarding concerns in accordance with the Brothers of Charity policy to the designated officer has already been addressed under outcome 8.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents were provided with a service during the day that suited their individual needs and preferences. Improvement was required in relation to an assessment of residents' personal and life skills development.

Residents in this centre were of an older age-group and how they spent their day matched their needs and wishes. Where residents chose to attend an active retirement day programme, this was facilitated. Lie-in's were also facilitated with a later start to the day for residents. Where residents were retired, an individualised service was provided in the house by day staff. As will be referenced under outcome 13, the plan for this centre in terms of how to facilitate residents close to retirement age going forward should they no longer wish to attend the active retirement programme required review.

The personal plan included sections for capturing residents' skills, including in relation to money skills, skills relating to household tasks and personal care. Staff described how

some residents were supported in different ways to be involved in meal preparation or managing their own laundry and this was captured in their personal plans. However, overall the information provided in residents' plans did not demonstrate how life skills were assessed or what programmes were developed to retain or develop existing or new skills or interests. Residents' plans did not contain information as to how skills programs in the day service were also supported in the residential service.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Overall, residents' healthcare needs were supported by staff. Further improvement was required in relation to healthcare plans.

Residents had access to their own general practitioner (GP) and medical consultants where required. Reports following such reviews were in residents' files. Residents had accessed different healthcare professionals on a referral basis, including speech and language therapy, dietetics and physiotherapy. Improvements required to ensure that residents' needs were being appropriately assessed were previously addressed under outcome 5.

Healthcare plans had been developed for residents by an appropriate health professional. Overall, plans reviewed directed the care and support to be provided to residents. Healthcare plans were required for some additional areas of need that had been identified in medical reports. such as a history of falls. Also, information in healthcare assessments viewed did not correspond with healthcare plans that had been developed.

Residents were supported to participate in making snacks or in meal preparation on an individual basis in accordance with their wishes. Residents took turns to accompany a staff member for the weekly shop on Friday evenings. Where residents had dietary needs, these were clearly laid out in a care plan. Where residents became unwell, advice in relation to maintaining adequate nutrition and hydration had been sought. Residents' weight was monitored and relevant records maintained where indicated. Residents were supported to make healthy living choices, for example in relation to healthy eating and

exercise. Staff demonstrated that they were aware of and understood how to implement the recommendations made by allied health professionals.

Each resident had an individual 'hospital passport' that contained key information should a resident be admitted to the acute hospital sector. Information contained in the hospital passport was specific to that resident and included information about allergies, their medication, communicating with the resident in relation to healthcare matters and any relevant risks.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall, there were policies and procedures in place in relation to medication management. Some improvements were required to ensure that medicines were administered as prescribed and safe storage of medicines.

There were written policies and procedures in place relating to the ordering, administration, storage and return of medication. Medicines were ordered from the pharmacy on a monthly basis. Medicines were checked on arrival in the centre and medicines with psychotropic properties were counted daily.

Medicines were stored safely in the centre in a locked cupboard. Staff outlined the procedure in place for the segregation and return of any medicines that were used or out of date. Medicines to be returned to the pharmacy were segregated from other medicines and a log of returns to pharmacy was maintained. A compliance aid (a 'biodose' system) was in use in the centre. Staff articulated how they would withhold or adjust the dose of a medication, on request of the prescriber.

There was a system in place for the administration and oversight of PRN medicines (as required medicines). The administration of psychotropic medication was reviewed by the person in charge and community nurse and by each resident's psychiatrist during any appointments or as required. The inspector observed that residents had an individual medication management plan in place and a PRN protocol. However, an inspector found that there were two protocols in place for some medicines with only one protocol approved by the psychiatrist. This would involve a risk of staff following the incorrect,

less detailed and unapproved protocol.

Also, records of PRNs administered were only maintained in the centre for a short period of time, before being sent to the community nurse. As a result, a full record of PRNs administered was not available in the centre to facilitate a review of whether or not the PRN was being administered as prescribed and for auditing purposes. Therefore, it could not be demonstrated that medicines were administered as prescribed.

Medication errors were recorded and reported. Corrective action was taken following any such errors and where required, this involved relevant third parties.

The inspector reviewed two most recent medication audits that had been completed by a pharmacist and by nursing staff. Gaps identified were being addressed. For example, where the pharmacist had identified that the medicines fridge was not storing medicines in the correct temperature range, a new fridge had been purchased. However, an inspector observed that the fridge, while in room that was capable of being locked, was not capable of being locked.

Judgment:

Substantially Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The Statement of Purpose for the centre was requested prior to this inspection. While Statement of Purpose outlined many of the items listed in Schedule 1 of the regulations, some areas did not meet the requirements of the regulations:

- the primary function of rooms in the separate apartment was not clearly described in the Statement of Purpose
- the description of how multidisciplinary supports are accessed by residents was not in line with the relevant regulations
- the specific care and support needs provided for in this centre required review to reflect the increasing age profile of residents living in this centre
- staffing arrangements and the day to day operation of this house required review to ensure that the service being provided reflected residents' increasing needs.

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):

No actions were required from the previous inspection.

Findings:

Overall, there were clearly defined management arrangements in place in the centre and the provider had taken a number of steps at organisational level to strengthen the systems in place to monitor the quality and safety of care being provided to residents. However, the oversight of these arrangements was not adequate and required review.

There was a clearly defined management structure in place in the centre. Care assistants and social care workers in the centre reported to the social care leader. The social care leader reported to the person in charge. The person in charge reported to the sector manager, who in turn reported to a representative of the provider, who was a member of the executive management team.

The person in charge had the qualifications and experience to fulfil the role of person in charge. There were appropriate deputising arrangements in place with the sector manager deputising where required.

The person in charge was responsible for five centres, comprising seven houses across Cork city and suburbs. Since the previous inspection, the remit of the person in charge had been reduced as day services had been removed from their area of responsibility. The person in charge said that they visited the centre once or twice a week on average with regular phone contact in between visits. The person in charge knew residents well and residents said they knew the person in charge also.

The person in charge was supported in her role in this centre by a social care leader, who was qualified and experienced in the field of social care. The social care leader was responsible for three houses and said that she visited this centre daily. The social care leader demonstrated that she knew the residents, their abilities, likes and dislikes. Staff told the inspector that they could bring any concerns to the social care leader or person in charge. The person in charge and social care leader in the centre met formally on a

fortnightly basis. Attendance at staff meetings, personal planning meetings and case meetings was shared between the person in charge and social care leader.

Unannounced visits had taken place in the centre, with the most recent review having taken place in May 2017 (two months prior to this inspection) by the standards and quality manager. The review identified that abusive incidents had been recorded in the complaints log, that threats can be made towards residents by their peers and suggests that a peer to peer issue may need to be monitored. However, there was no corresponding action in the action plan for these identified issues. Also, the visit did not explore whether safety plans or behaviour support plans were required or whether incidents or complaints that raised safeguarding concerns had been reported to the designated officer. Finally, the unannounced visit did not adequately consider the effectiveness of the governance arrangements in the centre.

An annual review of the centre had been completed by the person in charge. The review invited and considered relatives' experience of the service, including in relation to staff attitudes and approach, the quality and safety of care provided to their loved one and level of satisfaction with consultation. However, the annual review did not identify that there were safeguarding concerns in the centre or assess whether these had been reported in accordance with the organisation's policies and procedures. Also, given the failings identified on this inspection, it was not demonstrated that the manner in which the annual review was conducted constituted effective oversight or governance.

At organisational level, the provider had reviewed the arrangements in place in relation to the recording, reporting and management of complaints, risks and safeguarding concerns. New arrangements had been put in place to address these previously identified gaps. However, this inspection identified further gaps in relation to the implementation and oversight of those arrangements. The provider responded proactively to these identified failings and arranged for a review of those gaps and an assessment of the current situation in the centre.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of the obligation to submit a notification in the event of any proposed absence of the person in charge and the arrangements to cover for the absence.

There were adequate arrangements in place for the management of the centre when the person in charge is absent. A person participating in the management of the centre, identified to deputise for the person in charge in their absence, demonstrated a good understanding of the responsibilities when deputising for the person in charge.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

The centre was equipped and laid out in accordance with the Statement of Purpose. There was a system in place for identifying any required works or upgrading of the premises. The centre was free from obvious hazards. Transport was available to support residents to go to their day service, to appointments, for residents who were retired and to support home or family visits.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Overall, there were systems in place for the recruitment, supervision and training of staff. Staffing arrangements required review to ensure that residents would be offered meaningful choice in relation to how they spent their leisure time.

The centre had a policy for the recruitment of staff. An induction folder was available in the centre that provided guidance and information for staff. A sample of personnel records reviewed evidenced that the records contained the documents required by Schedule 2 of the Regulations.

The staff roster reflected the number of staff on duty. Staffing numbers were in line with those described in the Statement of Purpose. There was one staff member on duty in the centre each day from 17:00 onwards and slept in the centre overnight and was on duty until 09:30 the next morning. Day staff brought residents who attended a day service to and from their day service. There was one staff member on duty on Saturday and Sunday, inclusive of the overnights. However, it was not demonstrated that staffing arrangements facilitated resident choice in relation to outings, activities or pursuing individual interests. For example, an additional staff member was assigned to the centre on Friday evenings, but this was also the night that the weekly shop was completed. As a result, any time available for residents to benefit from one to one time on Friday evenings also had to include doing the weekly shop. Also, there was one staff on the roster during key hours on a Saturday (13:30 to 16:00) with four residents. While staff could be requested for planned outings or events, options for residents were limited outside of those pre-planned occasions.

Staff were knowledgeable of residents' individual needs and preferences. Staff training and assessment records indicated that the staff training programme included training in the areas of medicines management, fire safety, the protection of vulnerable adults, food safety and hand hygiene.

Systems were in place for staff supervision and appraisal and staff spoken with had participated in this programme.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

Overall, records and documentation were stored securely and made available for review.

Records were kept securely in a locked cupboard and confidential files stored securely and made available to inspectors for review where required.

While most of the records as required under Schedule 3 of the regulations were maintained, other required records were not available for review. This was previously addressed under outcome 12. Records listed in Schedule 4 to be kept in a designated centre were also made available to inspectors.

All the required policies and procedures as required under Schedule 5 were made available to the inspector. However, a number of Schedule 5 policies were outside of their review date. Staff with whom the inspector spoke demonstrated an understanding of specific policies such as the medication management policy. Easy-read versions of policies were also prominently displayed in the centre.

A directory of residents was maintained in the centre. A certificate of insurance was submitted on request prior to this inspection, which complied with all the requirements of the regulations.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Julie Hennessy
Inspector of Social Services

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 Brothers of Charity Southern Services
Centre ID:	OSV-0002300
Date of Inspection:	01 & 02 August 2017
Date of response:	25 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 02: Communication

Theme: Individualised Supports and Care

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

Where residents had communication needs, an assessment had not been completed by an appropriate health professional in relation to communication supports.

1. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all

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

times to communicate in accordance with the residents' needs and wishes.

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

The Person in Charge has:

- (1) Reviewed the residents Comprehensive Assessment of Need and amended this to reflect the residents' communication difficulties in advance of the updated annual review of the residents' plan (see Outcome 5 below) [24/08/2017]
- (2) Requested a consultation with a Speech and Language Therapist to provide guidance for the team supporting the resident. [24/08/2017]
- (3) Made a formal referral for an assessment of the residents' communication support needs [24/08/2017]

The residents' personal plan will be reviewed and updated following this assessment

Proposed Timescale: 31/10/2017

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:

As detailed in the findings, not all areas of need had been assessed by an appropriate health professional.

2. 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:

1. The Person in Charge has arranged for the compilation of a log of falls, behaviour issues and other significant events for the individual residents in the previous year
2. The Person in Charge has ensured that a Falls Assessment and Fall Care Plan are in place for one resident and that the Centre will manage falls in accordance with the policy
3. A meeting of the staff team with Psychology has been arranged to discuss the compatibility of the residents in the Centre, including the impact of dominant behaviours on all residents. This matter has also been discussed with the Designated Person see Outcome 8 below [01/09/2017]
4. The above issues will be considered as part of the annual review. This review will include members of the multidisciplinary team, which, in turn, will inform the revised annual plan for the residents. [31 October 2017]

Proposed Timescale: 31/10/2017

Theme: Effective Services

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

There was no multidisciplinary review of residents' plans.

3. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The Person in Charge has arranged for an annual review of the residents' plans to be undertaken with multidisciplinary team inputs.

Proposed Timescale: 31/10/2017

Theme: Effective Services

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

Behaviours of concern had not triggered an assessment of the suitability of the designated centre to meet each individual residents support needs.

4. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

1. The Person In Charge has consulted with Positive Behaviour Support Services to arrange the preparation of a Behaviour Support Plan for one resident.
2. A log of behaviours is now maintained to inform the Behaviour Support Plan, to inform the safeguarding plan (Outcome 8) and also to inform the scheduled consultation with Psychology on September 1 next (see Action 2 above)
3. The issue of compatibility will also addressed at the Annual Review and multidisciplinary recommendations will inform the residents' personal plans

Proposed Timescale: 31/10/2017

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:

As detailed in the findings, the system for assessing, managing and escalating risks was not sufficiently robust.

5. Action Required:

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

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

1. The Person in Charge will review all reports, complaints and risks to ensure that:
 - o All relevant risk assessments are in place and reviewed on an ongoing basis
 - o All incidents are recorded and reported correctly.
 - o Key risks are escalated where necessary
2. The Person in Charge will ensure that the staff team will receive updated training on risk management procedures including training on the management of safeguarding risks.

Proposed Timescale: 30/09/2017

Theme: Effective Services

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

The system in place for recording, reporting and analysing incidents and behaviours of concern was not being implemented in accordance with the organisation's incident management policy.

6. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

1. Staff training will be refreshed to ensure all staff team have sufficient understanding of safeguarding issues and of the services reporting systems.
2. To ensure that there is clarity for staff the Provider and Person in Charge have reviewed and amended safeguarding incident Reporting forms. A new standard reporting form will be put in place in the Centre which will oblige all staff to notify all safeguarding concerns however arising (i.e. arising from a complaint, verbally, behavioural incident etc.) on standard notification form to enable these to be analysed and managed in accordance with policy.

Proposed Timescale: 08/09/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

It was not demonstrated that the impact of behaviours of concern on residents experiencing those behaviours had been adequately assessed.

7. Action Required:

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

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

1. The Person in Charge has reviewed all incidents in the Centre in the past year and has developed an interim safeguarding plan with the Designated Person.
2. A log of behaviours will be maintained to inform the behaviour management plan development and all reviews of safeguarding plans by the Designated Person.
3. The Designated Person assessment of the impact of the behaviours of concern on the other residents will be sought to inform 4 & 5 below.
4. The log will also inform the scheduled consultation with Psychology on September 1 next (see Action 2 above)
5. The Multidisciplinary Annual Review will inform the plan for all residents including the plan to address any identified incompatibilities. Any plan to relocate residents due to incompatibility issues will be time-framed and notified to the Authority at that stage.

Proposed Timescale: 31/10/2017

Theme: Safe Services

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

A satisfactory understanding of how to identify, record and report safeguarding concerns was not demonstrated.

8. Action Required:

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

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

1. The Person in Charge has advised staff to report all concerns, suspected or confirmed, of potential abuse in the Centre using the definition of abuse under the Health Act 2007 (i.e. not using the HSE definitions which will be applied in consultation with the Designated Person post notification)..
2. Staff will be trained on how to identify concerns and how to the use of the new reporting form as part of the updated Safeguarding Training Workshop organised by the PIC

Proposed Timescale: 30/09/2017

Theme: Safe Services

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

As detailed in the findings, safeguarding procedures in place in the organisation had not been followed.

9. Action Required:

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

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

1. A full review has been conducted of all incidents in the Centre from the Individual Daily Report Books and other documentation to ensure completeness of reporting of incidents.
2. This review will identify if incidents have been notified to the Authority and HSE Safeguarding Teams where required.
3. Any incidents not reported will be retrospectively reported as appropriate.
4. A staff training and awareness session has been scheduled with staff, management and the Designated Person to ensure that all team members are fully aware of their obligation to report all concerns
5. The Provider will ensure that the Incident Report Policy is reviewed and clarified for frontline staff.

Proposed Timescale: 30/09/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

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

It was not demonstrated that all incidents that required reporting to HIQA had been reported in accordance with the Regulations.

10. Action Required:

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

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

A full review is being conducted of all incidents in the Centre, which will identify if incidents have been notified to the Authority as required.
Any incidents not so reported will be retrospectively reported as appropriate.

Proposed Timescale: 08/09/2017

Outcome 10. General Welfare and Development

Theme: Health and Development

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

As detailed in the findings, improvements were required to demonstrate how life or personal development skills were assessed or what programmes were in place to retain or develop existing or new skills or interests. Residents' plans did not contain information as to how skills programs in the day service were also supported in the residential service.

11. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

The Person in Charge has arranged consultations between residential and day service staff to assess and ensure that relevant skills teaching programmes in place for residents are supported across all settings.

All Residents plans will be reviewed and updated to reflect the outcome of these consultations

Proposed Timescale: 30/09/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

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

As detailed in the findings, healthcare plans were required for some additional areas of need that had been identified in medical reports. such as a history of falls. Also, information in healthcare assessments viewed did not correspond with healthcare plans that had been developed.

12. 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 log of significant events, including health care issues, for each resident for the past year has been compiled by the Person in Charge for review as part of the Annual Review.

The Person in Charge has ensured that a Falls Assessment and Fall Care Plan are in place for one resident and that the Centre will manage falls in accordance with the policy

Healthcare plans will be updated to ensure accurate recording of all health issues as

part of the annual review personal plans.

Proposed Timescale: 31/10/2017

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:

The medicines fridge was not capable of being locked, as outlined in relevant professional guidance.

13. Action Required:

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

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

The Person in Charge has arranged for a fridge locking device to be put in place. In the interim, the staff room where the fridge is located is locked.

Proposed Timescale: 30/09/2017

Theme: Health and Development

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

As detailed in the findings, improvement was required to demonstrate that medicines were administered as prescribed.

14. 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:

Records of PRN medication are reviewed by the PIC and Community Nurse. These records are now maintained in the Centre and review on site.

Proposed Timescale: 03/08/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The Statement of Purpose required review to meet the requirements of the regulations and to reflect residents' increasing needs.

15. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The Statement of Purpose will be reviewed and updated to ensure compliance with Schedule 1 of the Regulation and in particular will address

- the primary function of rooms in the separate apartment,
- procedures for access to multidisciplinary supports,
- the specific care and support needs provided for in this centre to reflect the age profile of residents and
- The associated staffing arrangements.

Proposed Timescale: 08/09/2017

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:

While an annual review of the centre had been completed it was not demonstrated that the manner in which the annual review was conducted constituted effective oversight or governance so as to ensure care and support provided is in accordance with standards.

16. 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:

The Provider Nominee will meet with the Person in Charge and PPIMs to revise the format of the Annual review to ensure that it captures the relevant care and support issues in the centre and reflects good governance on such issues and related actions for improvement.

Proposed Timescale: 30/09/2017

Theme: Leadership, Governance and Management

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

As detailed in the findings, the unannounced visits to the centre failed to adequately 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.

17. 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:

The Provider will review the system of action planning from the unannounced visits to centres with the relevant managers who undertake these visits to ensure that all concerns identified have a related action identified.

Proposed Timescale: 30/09/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

As detailed in the findings, it was not demonstrated how the number of staff was appropriate to the number and assessed needs of the residents and the statement of purpose of the designated centre.

18. Action Required:

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

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

The Centre's allocation of flexible social hours, currently held in a flexible central resource pool by the Person in Charge accessible by a number of Centres, will be devolved to the Centre for more local decision-making and to allow residents greater choice on their leisure time activities. [31/08/2017]

The staffing requirement of the Centre to support the residents will be reviewed and planned for by the PIC PPIM and Provider following the annual review of the personal plans of residents [31/11/2017]

The recruitment requirements to facilitate more local flexibility in the Centre will be identified by the PIC and additional staff will be recruited to provide this support.

[30/11/2017]

Proposed Timescale: 30/11/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

A number of Schedule 5 policies were outside of their review date.

19. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

All polices requiring review will be reviewed and available in the Centre.

Proposed Timescale: 14/09/2017