

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Camphill Community Grangemockler
<b>Centre ID:</b>	OSV-0003622
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Camphill Communities of Ireland
<b>Provider Nominee:</b>	Adrienne Smith
<b>Lead inspector:</b>	Raymond Lynch
<b>Support inspector(s):</b>	Gary Kiernan
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	19
<b>Number of vacancies on the date of inspection:</b>	2

## **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 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
30 August 2017 17:30	30 August 2017 21:00
31 August 2017 09:00	31 August 2017 14:30

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 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

**Background to Inspection**

This was a triggered inspection after the Health Information and Quality Authority (HIQA) received unsolicited information concerning a number of drug errors occurring in the centre and the staffing arrangements in place to provide a safe service to the residents. Information also received by HIQA expressed concerns about the centres over reliance on co-workers (volunteers) in providing care and support to the residents.

The centre was last inspected in November 2016 where good levels of compliance were found across the majority of outcomes assessed. Further to that inspection the centre was registered with HIQA in early 2017.

However, since that inspection, a number of core staff members had left the service (of which those vacancies had yet to be filled), a new group of co-workers had commenced volunteering in the centre (who had no experience of these residents) and the assessed needs of some of the residents had changed considerably.

This inspection found, that while the person in charge was responsive to the regulatory process and was making a concerted effort to provide safe, person centred services with the limited resources she had available to her, the unsolicited information received by HIQA was substantiated and residents were in receipt of a

service that was unsafe and not adequately meeting some of their assessed needs.

How we gathered our evidence:

The inspectors met and spoke with two staff members, a relief staff member, two agency staff members and a volunteer over the course of this inspection process. The person in charge was also spoken with at length over the course of the two days.

The inspectors also got to meet with three residents and spoke with them briefly.

Policies and documents were also viewed as part of the process including a sample of records of adverse incidents occurring in the centre, medication files, positive behavioural support plans and safeguarding plans.

Description of the Service:

The centre comprised of 4 large separate detached houses supporting 19 residents in total. For the purpose of this inspection the inspector visited two of those houses. All houses were in a rural location and within walking distance to each other.

The centre was in close proximity to a small nearby village however, transport was also provided so as residents had access to local amenities further afield.

Overall Judgment of our Findings:

Of the five outcomes assessed in this inspection four were found to have major non-compliances. These were Risk Management, Medication Management, Workforce and Governance and Management. Safeguarding was assessed as having a moderate non-compliance.

It was found that practices regarding the administration of medication required urgent review and access to allied healthcare professionals was inadequate which resulted in the inspectors issuing two immediate actions concerning the medication management practices in the centre.

The Provider Nominee and Person in Charge responded to the immediate actions by providing a detailed action plan on how they intend to address the concerns as raised by HIQA.

These issues are further discussed in the main body of this report and in the action plan at the end.

**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):**

No actions were required from the previous inspection.

**Findings:**

This inspection found that the systems in place for assessing, reviewing and managing the risk associated with medication incidents and errors were not adequate and placed residents at risk as a result.

On viewing a number of incident report forms the inspectors were concerned that a significant number of medication errors had occurred in the centre over the months of May, June, July and August 2017.

Documentation retrieved by the inspectors informed that these errors included incorrect administration of medication, medication not being administered when it should, the use of (as required) p.r.n. medicine not in line with strict administration protocols and medication going missing.

This situation concerned the inspectors as some residents were on medication for the management of epilepsy while others were on prescribed medication to support their mental health.

It was also observed that in many instances it was not possible to identify which staff members or volunteers were responsible for making the errors.

Inspectors issued an immediate action concerning this issue seeking immediate reassurances that it would be addressed as a matter of urgency.

The provider nominee and person in charge responded to these concerns as raised by HIQA by taking immediate steps to review and oversee the administration of medicines. This included, for example, ensuring that medications could only be administered by competent and experienced staff. This was observed to be underway before the close of day two of the inspection. In addition the provider gave written assurances that a nurse (who will also act as a person participating in management) would be recruited to the centre by November 6th 2017 in order to support medication practices across the

centre.

The provider gave assurances that a newly appointed Regional Manager will meet with the person in charge on September 5th 2017 to provide ongoing management support and will also attend weekly management meeting. The Regional Manager will also provide regular six weekly supervision meetings with the person in charge.

The provider also responded to HIQA's concerns by informing HIQA that a Safeguarding & Policy Officer has been recruited and will be in post in the centre by October 10th 2017. They will be responsible for all aspects of safeguarding in everyday practice. The provider also outlined that the recruitment of additional social care trained staff will commence as a priority and there will be a new roster in place in one of the houses which will stipulate that a senior person will be in place each day for the safe oversight of medication administration.

Finally, a system of check lists will be used at the start and end of every shift which will include a stock check number. This will facilitate management to deal with any risk associated with medication more effectively and also identify what staff member and/or volunteer made the error.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

As identified in Outcome 7, Risk Management, the frequency and level of medication errors occurring in this centre was of significant concern to the inspectors. It was also observed that there was inadequate support being provided from allied healthcare professionals such as psychology and behavioural support.

The arrangements for providing positive behaviour support were not satisfactory. There was a significant lack of support from allied healthcare professionals in this centre. Some of the residents' assessed needs had changed significantly over the last few months

however, the service only had access to behavioural a support specialist for one half hour per month and a psychologist for one half hour per month. As a result inspectors saw evidence that some behavioural support plans which were in place were not up to date.

Of the staff spoken with they informed the inspectors that this situation was not adequate in meeting the assessed needs of some of the residents and that it was an on-going struggle to secure and provide adequate allied healthcare support.

Documentation retrieved by the inspectors informed that the person in charge was very concerned about this situation and stated that due to a significant lack of funding and resources the centre could not continue to provide a safe service to residents.

It was also observed that one resident with significant complex needs required a quiet and calming environment as part of their behavioural support. However, the house he lived in could be noisy at times as another resident liked to play and listen to loud music.

The arrangements for overseeing the administration of as required (prn) medication, which could be considered a restrictive practice, were not adequate. Inspectors saw records which showed that a significant number of doses of (prn) psychotropic medication had been administered. This medication was prescribed and a protocol was in place to support its consistent administration.

However, the records which were maintained did not demonstrate that this protocol had been adhered to in all cases. It was also not demonstrated that this practice had been assessed or reviewed in terms of restrictive practice.

**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:**

This inspection found that the procedures in place for the ordering, storing and administration of medication were not safe and put residents at risk.

There had been a significant amount of medication errors recorded in this centre over the last four months. The management and auditing systems did not provide for an

accountable system and did not inform management who was responsible for a number of these errors. Action taken in response not always timely or targeted and ultimately was not effective as incidents occurred over a significant length of time.

It was also observed that on other occasions the ordering and receipt of the medication required review as at times the centre was not receiving an adequate amount of medication required for each resident.

On a number of occasions it was also recorded that medications were found on the floor or had gone missing.

Inspectors issued an immediate action of which resulted in the person in charge and provider nominee undertaking to implement the following actions:

1. Medication presses and files in the 4 community houses were audited the next day
2. Rosters were reviewed to ensure there were suitably qualified and experienced personnel on site to administer medication in line with policy and regulation
3. A full audit of the medication processes was requested and has been scheduled.
4. The provider's national medication coordinator committed to having the audit report completed and forwarded to HIQA and the Provider Nominee by Friday 8th September.
5. The national medication coordinator will discuss the audit findings with the person in charge and the deputy person in charge  
Regional Manager & Provider Nominee
6. The audit will be provided to HIQA on completion of same
7. There will be four half days training arranged with local pharmacist to train staff on a house by house basis.

This pharmacist has the medication training manual and is also involved in the dispensing of all the medications to the community so is familiar with resident specific requirements.

The Provider provided written assurances that all of the above actions would be completed by September 8th 2017

**Judgment:**

Non Compliant - Major

**Outcome 14: Governance and Management**

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

**Theme:**

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

No actions were required from the previous inspection.

**Findings:**

The systems of governance and management were assessed as not being adequate to ensure the residents were in receipt of a safe service. Systems were not adequate to ensure adequate oversight of areas of risk and to ensure that effective and timely action was taken where risk issues were identified. As a result of this there was evidence of direct negative outcomes for residents.

There were audits and documented incidents which showed that corrective action needed to be taken in response to medication safety. However, the provider's management systems were not responsive. In addition the provider's systems for responding to the changing needs of residents coupled with a reliance on volunteers to support residents with complex needs was not satisfactory and did not promote positive outcomes for residents.

The person in charge was spoken with at length over the course of this inspection. She was a qualified social care professional with significant experience of working in residential settings.

She was found to be very responsive to the inspection process and indeed was very much aware of her remit to the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (The Regulations).

It was also found that she was aware of the issues impacting on the centre and was making every efforts to address them. However, she was significantly challenged by the lack of resources at hand and the provider's engagement with the centre. This was further complicated by the recent departure of a number of core staff, an intake of a new group of volunteers and the individual needs of some of the residents were changing and becoming increasingly significant.

Documentation retrieved by the inspector informed that the person in charge had made her concerns known and had escalated concerns to the provider and to the funder of the organisation about the quality and safety of care being delivered to the residents.

**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):**

No actions were required from the previous inspection.

**Findings:**

This inspection found that the numbers and skill mix of the staff working in the centre required review.

The inspectors got to speak with a number of staff members (core staff, agency staff and relief staff) over the course of this inspection.

While it was found that they were knowledgeable of the needs of the residents and treated them with dignity and respect it was observed that there was an over reliance on agency staff and volunteers in providing care and support to the residents.

For example, on the evening of the first day of the inspection one of the houses where residents presented with complex needs was being staffed with a relief worker, an agency staff member and a volunteer for night duty. Inspectors spoke with a member of staff and it was apparent that they did not have an in-depth knowledge of the residents' assessed needs.

This concerned the inspectors as the centre was reliant on some volunteers to undertake core tasks such as the administration of medication. It was also observed that there had been a significant amount of medication errors made over the last four months. The staffing model as observed did not support continuity of care and a homely environment for residents.

This inspection also found that a number of core staff had recently left the centre and their posts had yet to be filled.

**Judgment:**

Non Compliant - Major

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Raymond Lynch  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Camphill Communities of Ireland
<b>Centre ID:</b>	OSV-0003622
<b>Date of Inspection:</b>	30 & 31 August 2017
<b>Date of response:</b>	28 September 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 for assessing, reviewing and managing the risk associated with medication incidents and errors were not adequate and placed residents at risk as a result.

**1. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated

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

centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

The national incident medication reporting forms have been amended to include identification of persons responsible for errors. It also includes improvements in identification of location where an error occurred. (Completed 27/09/2017). The Person in Charge will ensure these are completed for the Designated Centre.

The national audit registers have been amended to include identification of persons responsible for errors thus enabling local, regional and national managers to identify persons involved in errors and the location within the Centre thus improving the systems for reviewing errors. The Person in Charge will ensure these are completed for the Designated Centre.

The Appointment of a qualified Nurse, who is appointed as Deputy Person in charge, with responsibility of Nursing requirements for the residents, for overseeing the Medication systems, working with the National coordinator of medication, and to provide ongoing training for staff, in the designated centre. She will take up her post on the 23rd of October.

The national medication coordinator carried out a detailed medication Audit on the 4/09/2017, in the designated centre, and actions following the Audit have been put in place. There is a daily check by suitable trained staff in the morning and in the changeover of shifts, this is Carried out by two people.

The newly appointed Regional manager met with the Person in Charge on the 5th of September, and set up a schedule of 6 weekly supervision meetings with the person in charge. She attended the weekly welfare meeting and will meet weekly with them until the Nurse has commenced in her post, she will she attend the meetings monthly thereafter.

The regional manager will attend the Managers meeting on a monthly basis.

The reporting of medication errors has been strengthened to ensure where there is a potential serious consequence identified, as part of the medication error risk management process or where medical advice obtained has identified serious potential risk, the medication error is notified to the Regional Manager for senior management instruction and guidance thus ensuring there is oversight and monitoring. The Regional Manager in turn reviews the response with the National Policy & Social Care Coordinator and Safeguarding Co-ordinator. Feedback, advice and instruction are provided to the Person in Charge by the Regional Manager.

The Regional Manager review of medication errors has commenced as a part of the routine incident management process. There will be monthly sign off of medication incident management. Patterns of medication errors are being reviewed as part of this process along with actions taken or required to be taken to address concerns. In turn the outcome of this oversight is escalated and reviewed nationally through senior management meetings.

There is a new Deputy Person in Charge appointed and will commence in her post on the 10th October 2017. She will have specific responsibility for overseeing Safeguarding in the Designated centre.

**Proposed Timescale:** 23/09/2017

## **Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

There was a significant lack of support from allied healthcare professional such as behavioural support specialists. This in turn meant that some of the assessed needs of some of the residents were not adequately addressed. It was also difficult to implement parts of a positive behavioural support plan as the environment could be busy and loud at times. Of the positive behavioural support plans which were in place, some had not be reviewed in a timely way.

### **2. Action Required:**

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

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

Person in Charge has made contact with the HSE in relation to one person with changing needs, to address his care needs into the future. The Person in Charge is developing a transition plan with him and his support network.

The service provider is recruiting a Psychologist / Behavioural support specialist, to work closely with the designated centre in developing behavioural support plans, and offer advice and support to the staff team in the designated centre

**Proposed Timescale:** 31/12/2017

**Theme:** Safe Services

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

The arrangements for overseeing the administration of as required (prn) medication, which could be considered a restrictive practice, were not adequate.

### **3. Action Required:**

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive

procedure, for the shortest duration necessary, is used.

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

The national medication coordinator carried out an Audit of the medications in the Designated Centre which included the use of PRN medication, as a result the Protocols of the administering of PRN medication has been reviewed and is updated.

The Nurse that has been employed and will be commencing on the 23rd of October 2017, will have responsibility with the Person in Charge for reviewing the MARS sheets and ensuring the protocols are kept up to date, she will also have responsibly to ensure that PRN medications are only used according to the protocols, and are documented correctly.

**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 procedures for the storage and administration of medication were not safe and put residents at risk.

**4. 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:**

Significant staff training has taken place, both with the National Medication coordinator and The Local Pharmacist, who both know the medication needs of the residents in the designated centre,

All medications are stored in a locked press, and each resident has their own cubicle in the press for the storage of their medication. The pharmacy is now delivering the medication to the Designated centre. Medication that needs to be disposed is brought to the Pharmacy for disposal

Medication presses and files in the 4 community houses were audited on the 30th and 31st of August.

A new checklist for medication has been put in place, to be used at the being and end of every shift, which includes a stock check. This is to allow the team to isolate on the day, any errors that have occurred and what training / Additional support are needed to address the issue. PIC & DPIC (Nurse) to be informed if error is identified.

The new Nursing post will have responsibility for ordering and disposing of any medication, she will also ensure the MAR charts are update and reviewed regularly

**Proposed Timescale:**

**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 centre was not being adequately monitored and there was a lack of oversight from a governance and management perspective.

**5. 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 Regional Manager has put in place a schedule for carrying out at least six monthly unannounced inspections. A copy of the unannounced inspection report will be submitted to the inspector on completion.

The Provider has improved the tools and review process for incident reporting. There is improved oversight as outlined in response to Outcome 7

**Proposed Timescale:** 15/11/2017

**Theme:** Leadership, Governance and Management

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

The current systems in place did not ensure that the service being delivered was appropriate or safe

**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:**

The Provider has put in place a Regional Management Structure across three areas of its operations to strengthen governance and management of the designated centre.

The Regional Manager for this area commenced in post on the 04/09/2017

The Regional Manager will assume the role of Provider Nominee for the designated

centres she has responsibility for and have appropriate authority to ensure the management and control of operations in the Designated Centre.

The Regional Manager is supervised by the National Policy & Social Care Coordinator. There are clear reporting lines in place including the reporting and review of incident management and unannounced inspection outcomes.

Fortnightly Senior Management Team meetings attended by Regional Managers, the national safeguarding coordinator, national policy & social care coordinator and chaired by the Chief Operations Officer have been put in place. At these meetings the management of centres is a standard agenda item and covers health & safety, safeguarding, incident and risk management.

The Regional Manager has commenced supervision and put in place six weekly scheduled supervisions with the Person in Charge.

Two additional deputy persons in charge have been appointed within the Designated Centre. They will be PPIMs and strengthen the management structure in the Designated centre. One post has responsibility for Safeguarding and the other is a Nurse Manager post with oversight of health care and medication management. The existing DPIC is the care coordinator for the designated centre.

Quarterly MDT review meetings of significant cases will take place to consider most challenging cases. The review meetings will also consider changing needs of residents to ensure these are being met.

**Proposed Timescale:** 23/10/2017

## **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The numbers and skill mix of staff working in this centre required review

### **7. 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:**

In each house in the Designated Centre there will be a House Coordinator and Deputy House Coordinator with suitable qualified care staff in place as required to meet the needs of the residents.

A rota is in Place for the Deputy persons in charge to provide management cover for the community at the weekends. At night there is a designated qualified staff who is rostered on call for community.

One Deputy house coordinator has been employed. There is a need to recruit 4 new

qualified Care staff, and one House coordinator post, the person in charge has started the recruitment process for these posts.

**Proposed Timescale:** 30/11/2017

**Theme:** Responsive Workforce

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

There was an over reliance on volunteers to provide care and support to the residents in this centre

**8. Action Required:**

Under Regulation 30 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in writing.

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

The outcome of the actions outlined in action 7 above will reduce the over reliance on volunteers.

The Provider, Regional Manager, PIC and DPIC will review the current "Responsibility profile for Volunteers & Coworkers" in line with the changing role of co-workers.

**Proposed Timescale:** 30/11/2017