# Health Information and Quality Authority

## Regulation Directorate

## Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Teach Solas/Oaklands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003761</td>
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<tr>
<td>Centre county:</td>
<td>Longford</td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Jude O'Neill</td>
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<tr>
<td>Lead inspector:</td>
<td>Maureen Burns Rees</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>9</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>19 September 2017 09:30</td>
<td>19 September 2017 17:00</td>
</tr>
<tr>
<td>21 September 2017 10:00</td>
<td>21 September 2017 16:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

Background to the inspection:

This was a seven outcome inspection carried out to inform a registration renewal decision. It was the third inspection of the centre. The previous 14 outcome inspection was undertaken on the 29 November 2016 and as part of the current inspection the inspectors reviewed the actions the provider had undertaken since the previous inspection.

How we gathered our evidence:

As part of the inspection, the inspector spent time with, and spoke to four of the residents in one of the houses and three of the residents in the other house. The inspectors observed warm interactions between the service users and staff caring for them in both houses. All of the service users appeared to be in good spirits.

The inspector met with the two relatives of a service user living in one of the houses, an assistant director of nursing, the person in charge, three staff nurses, including the senior staff nurse assigned to one of the houses and two healthcare assistants. The inspector reviewed care practices and documentation such as support plans, medical records, incident report form, policies and procedures and staff files. In
addition, the inspector reviewed questionnaires completed by key workers on behalf of a number of individual residents and ones completed by relatives which outlined their views of the service.

Description of the service:

The service provided was described in the providers statement of purpose, dated February 2017. The designated centre consisted of two houses located a short car drive away from each other and a medium sized town. The centre provided a home for nine adults with a diagnosis of an intellectual disability and autism. Both of the houses were wheelchair accessible which promoted accessibility for all service users.

Overall judgment of our findings:

Overall, the inspector found that service users had a good quality of life in the centre and the provider had arrangements in place to promote their rights and safety. The person in charge demonstrated adequate knowledge and competence and the inspector was assured that she remained a fit person to participate in the management of the centre.

Good practice was identified in areas such as:

- Resident's well being and welfare was maintained by a high standard of evidenced-based care and support. (Outcome 5)
- Each resident's healthcare needs were appropriately assessed and met by the care provided in each of the houses (Outcome 11)
- There were systems in place to ensure the safe management and administration of medications. (Outcome 12)

Some areas of non compliance with the regulations and the national standards were identified which included:

- The provider had not investigated an allegation of abuse, which had been made some two years previously, in a timely and prompt manner. (Outcome 8)
- Improvements were required so as to ensure that the provider met its regulatory responsibilities in terms of monitoring the quality and safety of the service. (Outcome 14)
- Staff supervision arrangements required some improvement. (Outcome 17)
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Resident's well being and welfare was maintained by a high standard of evidenced-based care and support.

Each resident's health, personal and social care needs had been assessed. Personal plans had been put in place for service users in each of the houses and involved consultation with the service user and their family. There was evidence that goals were set and monitored for residents on a regular basis. The plans outlined individual wishes and preferences. It was noted that residents had achieved a number of goals set in the preceding period. For example, going on a short holiday. Accessible versions of individual residents personal plans had been devised onto posters and were on display in individual residents bedrooms.

There were processes in place to review resident's personal care plans with the involvement of family representatives on at least a yearly basis. Two relatives spoken with outlined how they felt that their relatives needs were fully met in the centre and that they were fully consulted with regarding their loved ones care and support.

It was evident that the residents engaged in a good range of activities in the community, which was dependent on the individual residents ability and preferences. Resident's wishes and choices for social activities were well supported. These included attending local musical events, agricultural shows, sensory room in a local town, bowling, walks, swimming, shopping trips and going on short hotel breaks. Residents had an activity schedule in place and records were maintained of the activities that they engaged in.
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):**

No actions were required from the previous inspection.

**Findings:**

The health and safety of residents and staff were promoted. However, some improvements were required in one of the houses from an infection control perspective.

There was a risk management policy, dated July 2016, which met the regulatory requirements. There was a safety statement in place, dated January 2017, with written risk assessments pertaining to the environment and work practices. The inspector reviewed a sample of individual risk assessments for residents which contained a good level of detail, were specific to the resident and had appropriate measures in place to control and manage the risks identified. There was an emergency evacuation plan, dated August 2016, to guide staff in the event of such emergencies as power outages or flooding.

There were arrangements in place for investigating and learning from serious incidents and adverse events involving residents. Overall, there were a low number of incidents and accidents in the centre. Actions taken as a result of an incident were also recorded. The inspectors reviewed staff team meeting minutes which showed that specific incidents were discussed with learning agreed. This meant that opportunities for learning to improve services and prevent incidences were being promoted. Records showed that the acting assistant director of nursing and person in charge met on a monthly basis to review all incidents and identify any trends and agree actions and learning to minimise reoccurrence. The inspector reviewed a sample of incident report forms and found that an appropriate record was maintained of actions taken and follow up proposed. All forms were signed off by the person in charge.

There were satisfactory procedures in place for the prevention and control of infection. However, in one of the houses there was chipped paint on walls and woodwork which negatively impacted on the effective cleaning of the areas from an infection control perspective. The inspector observed that all other areas were clean and generally in a good state of repair. There was a cleaning schedule in place which was monitored by the person in charge. Colour coded cleaning equipment was used and securely stored. Records were maintained of tasks undertaken. The inspector observed that there were sufficient facilities for hand hygiene available and paper hand towels were in use in the
centre. Posters were appropriately displayed. Staff had attended hand hygiene training.

Adequate precautions against the risk of fire were in place. The fire alarm system, fire fighting equipment and emergency lighting were serviced and checked at regular intervals by an external company and as part of internal checks in the centre. The inspector noted that the fire alarm system in one of the houses was overdue to have its quarterly service on the first day of inspection. However, this was addressed before the end of the inspection. There was adequate means of escape and fire exits were unobstructed. A procedure for the safe evacuation of residents in the event of fire was prominently displayed in both houses. Personal emergency evacuation plans were in place for residents which adequately accounted for the mobility and cognitive understanding of the resident. Staff who spoke with the inspector were familiar with the fire evacuation procedures. Fire drills were undertaken in both houses on a regular basis and included a simulated night time fire drills periodically.

Staff spoken with, were knowledgeable about manual handling requirements. Training records showed that staff had attended manual handling training. Ceiling tracked hoists were in place in both houses for residents identified to require same. Records showed that hoists in place had been appropriately serviced.

**Judgment:**
Substantially Compliant

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

**Theme:**
Safe Services

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

**Findings:**
There were appropriate measures in place to keep residents safe and to protect them from abuse. However, an investigation into an allegation of abuse in one of the houses, more than two years previously, had not yet been completed and residents or their family had not been appropriately communicated with.

The centre had a procedure for dealing with suspicious and allegations of abuse, dated May 2016 which was in line with national policy. Inspectors observed staff interacting
with residents in a respectful and warm manner. Staff who met with the inspectors were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. A picture and the contact details for the designated person for any allegation or suspicion of abuse was on display in both of the houses. Training records showed that staff had received appropriate safeguarding training. There had been no allegations or suspicions of abuse in the previous 12 month period.

Just over two years ago, a serious allegation of abuse was made in one of the houses. Suitable safeguarding arrangements had been put in place, at that time to ensure the safety of all residents. These safeguarding arrangements remained in place. The provider commissioned and commenced an independent investigation in early 2016. Unfortunately this investigation had not yet been completed. Residents and their families were appropriately told about the allegation at the time it was made, but had not been communicated with since regarding the investigation or timelines involved. The inspector spoke with two relatives who outlined their concerns regarding the time taken to complete the investigation and the negative impact of not having an informed view as to whether the alleged abuse had occurred or not. At the time of the last HIQA inspection in November 2016, the provider (as commissioner of the investigation) had advised HIQA that they envisaged the investigation would be completed by April 2017. However, this timeline had now passed. On this inspection, the provider advised that the investigation team had indicated that the work would be completed by the end of October 2017.

There was guidelines on intimate care, dated May 2016. There were also resident friendly accessible intimate physical care guidelines in place. There were detailed intimate care plans in place which provided guidance for staff to meet individual residents intimate care needs and preferences.

Residents were provided with emotional and behavioural support that promoted a positive approach to the management of behaviour that challenges. Some behaviours that challenge was displayed by a small number of residents. There was a strategy for the overall support of individuals who present with behaviours of concern, dated September 2014 and a procedure for the use of restrictive practice, dated November 2013. Both of these documents were overdue for review which meant that staff may not have had access to the most up-to-date best practice to guide their practice. There was evidence that regular positive behaviour support meetings were held with members of the multidisciplinary team for residents who presented with behaviour that challenged. Proactive and reactive strategies had been devised by a psychologist for residents deemed to require same and were regularly reviewed. Staff interviewed were familiar with the management of challenging behaviour and de-escalation techniques. Staff had all received training in the technique adapted by the centre to manage behaviours that challenge.

There were a small number of restrictive practices used in the centre and these were regularly monitored and reviewed. Staff interviewed told the inspector that all alternative measures were considered before a restrictive procedure would be put in place. Protocols for PRN or as required chemical restraint medications were in place and regularly reviewed.
**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Health and Development

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

**Findings:**
Each residents healthcare needs were appropriately assessed and met by the care provided in each of the houses.

Residents medical needs and support requirements were outlined in their personal plans and assessments. There was a staff nurse on-duty at all times in both of the houses. This meant that residents healthcare needs were being met with suitable expertise. Each of the residents had an up-to-date hospital passport in place with appropriate information should a resident require to be transferred to hospital in the event of an emergency.

Each of the resident’s had their own general practitioner by whom they were regularly reviewed. Information on specific conditions were available in the centre and individual care plans were in place to guide staff. Residents weights and blood pressures were checked and recorded on a monthly basis. A number of the residents were accessing allied health professionals which was supported. For example, a number of residents had physiotherapy exercise programs in place which were being followed by staff with records maintained.

Each of the houses had a fully equipped kitchen and dining area. The service had a policy on the provision of nutritionally balanced meals and guidelines for staff when supporting individuals during meal times. A range of nutritious, appetizing and varied foods were available in both of the houses. Weekly menu planners were in placed which should that a variety of balanced meals were provided for residents. Records were maintained of dietary intake for service users. Meal times were at times which suited residents and the inspector observed that these were a social occasion with staff joining residents for their meals. Pictured menu cards were available to support individual service users in making choices where required. A resident in one of the houses had an enteral feeding regime and there were suitable arrangements in place for the management of same.
**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:**
There were systems in place to ensure the safe management and administration of medications.

There was a guideline for the ordering, receipt, transport, safe administration and secure storage of all medications, dated December 2015. There was a staff nurse on duty at all times in both houses who was responsible for the administration of all medications. All staff, including support staff had received appropriate training in the delivery of a rescue medication required by a number of staff. Staff interviewed had a good knowledge of appropriate medication management practices. All medications were appropriately stored in a secure cupboard in each of the houses. The inspector reviewed a sample of prescription and administration sheets and found that medications were administered as prescribed.

There were appropriate procedures in place for the handling and disposal of unused and out of date medications. A form to record medications returned to the pharmacy was in place and had recently been revised to include the signature of the staff member returning the medication and the receiving pharmacist.

There were a small number of chemical restraints used in the centre. There were appropriate medication PRN or as required protocols in place for individual residents. These had been signed by the identified residents physician. All usage was regularly monitored and appropriately recorded.

There were systems in place to review and monitor safe medication management practices. Regular audits of medication practices were undertaken by staff and there was evidence that actions were taken to address issues identified. The pharmacist also undertook an audit every six months.

**Judgment:**
Compliant
**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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
There were management systems in place to ensure that the service provided was safe, consistent and appropriate to residents needs. However, improvements were required so as to ensure that the provider met its regulatory responsibilities in terms of monitoring the quality and safety of the service.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge was in a full time post and did not hold responsibility for any other centre. She was supported by a senior staff nurse in each of the houses. Staff interviewed told the inspector that the person in charge was a good leader, approachable and supported them in their role. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards. She also had a clear insight into the health needs and support requirements for residents in both of the houses. Residents were observed to interact with the person in charge in a warm manner.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. Staff who spoke with the inspector had a clear understanding of their role and responsibility. The person in charge reported to the assistant director of nursing who in turn reported to the regional director of nursing.

An annual review of the quality and safety of care and support for 2016 had been undertaken and made available to families. An unannounced visit to review the safety and quality of care had been undertaken in one of the houses only, a few days previous to the inspection. An improvement action plan to address issues identified had been put in place, with an appropriate assignment of responsibility and timelines. However, an unannounced visit on six monthly period, as required by the regulations, had not been undertaken in the preceding period.

There was an audit schedule in place which was overseen by the person in charge. Matters audited included, care planning, person centred plans, financial management, restrictive interventions, medication management, health and safety, complaints, privacy and intimate care. There was evidence that appropriate actions were taken to address any issues identified. Quality and safety governance meetings were held on a regular...
basis. These were attended by members of the senior management team. There was
evidence that results of audits and trends of incidents were reviewed at these meetings
with shared learning across the service agreed.

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

Findings:
There were appropriate staff numbers and skill mix in place to meet the assessed needs
of residents. However, staff supervision arrangements required some improvement and
some staff files did not meet all of the requirements of schedule 2 of the regulations.

There were recruitment procedures in place. There were a number of vacancies in both
of the houses which were being filled by the same agency staff over a prolonged period.
This meant that residents had continuity in their care givers. There was evidence that
these agency staff were in the final stages of recruitment to take up permanent
positions in the centre. The skill mix, numbers and qualifications of staff were suitable to
meet the assessed needs and support requirements of residents. Staff spoken with,
demonstrated a good knowledge of the residents needs and support requirements. A
small number of new staff had recently taken up positions in the centre and they
reported that they had felt supported and received an appropriate induction. There were
actual and planned staff rosters in place which had been appropriately recorded.

The inspector reviewed a sample of staff files and found that the majority of information
as required by schedule 2 of the regulations were in place. However, there were a small
number of files in the sample reviewed, were information such as a full employment
history and details of current registration status for staff nurses was not available.
Discrepancies were addressed on the day of inspection for the sample reviewed.

Training records showed that mandatory training requirements were up-to-date for the
staff team in both of the houses. The inspector noted that other training had been
identified and provided for staff in areas such as autism, dementia and dysphagia.
Staff supervision arrangements had been introduced at the start of the year. This meant that staff performance could be formally monitored in order to address any deficits and to improve practice and accountability. There was a supervision policy in place, dated May 2016. The inspector reviewed a sample of staff supervision records and found that they were of a good quality. However, supervision was not being undertaken in line with the frequency proposed in the providers policy.

No volunteers were working in the centre at the time of inspection.

**Judgment:**
Substantially Compliant

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**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:**

Maureen Burns Rees
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Health Service Executive</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003761</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>19 &amp; 21 September 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>09 October 2017</td>
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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:
There was chipped paint on walls and woodwork in one of the houses which negatively impacted on the effective cleaning of the areas from an infection control perspective.

1. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Please state the actions you have taken or are planning to take:**
There is a plan in place to paint one of the houses in the designated centre to ensure effective cleaning is maintained.

**Proposed Timescale:** 30/06/2018

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**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was a strategy for the overall support of individuals who present with behaviours of concern, dated September 2014 and a procedure for the use of restrictive practice, dated November 2013. Both of these documents were overdue for review which meant that staff may not have had access to the most up-to-date best practice to guide their practice.

2. **Action Required:**
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**
There is a plan in place for the review of the service policy’s to include the management of behaviour that challenges and for the use of restrictive practices.

**Proposed Timescale:** 30/06/2018

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The provider had not investigated an allegation of abuse, which had been made some two years previously, in a timely and prompt manner.

Residents and their families had not been appropriately communicated with regarding the on-going investigation into an allegation of abuse in the centre or of the timelines involved.

3. **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:**
There is a HSE internal investigation which is on-going at present. The investigation team have advised that it is due to conclude.

The regional Director of Nursing will communicate with the residents and their families with regard to the on-going investigation into the allegation of abuse in the centre and the proposed timelines involved. 13/10/2017

**Proposed Timescale:** 30/10/2017

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**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 provider had not undertaken an unannounced visit to the centre, at least every six months and produced a written report on the quality and safety of care and support in the centre.

4. **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:**
There is a plan in place for the provider or a nominated person to carry out an unannounced visit to the designated centre and produce a written report on the quality and safety of care and support in the Centre.

**Proposed Timescale:** 30/12/2017

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were a small number of files in the sample reviewed, were information such as a full employment history and details of current registration status for staff nurses was not available.
5. **Action Required:**
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

**Please state the actions you have taken or are planning to take:**
The PIC has undertaken a full review of all staff files in the designated centre to ensure all information as outlined in schedule 2 is in place.

All information such as full employment history and details of current registration status for staff nurses is now available in the designated centre.

**Proposed Timescale:** 26/09/2017

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Supervision was not being undertaken in line with the frequency proposed in the providers policy.

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

**Please state the actions you have taken or are planning to take:**
The template for staff supervision in the designated centre has been revised to reflect the appropriate frequency of supervision as proposed in the providers’ policy.

The PIC will carry out staff supervision in the designated centre as proposed in the staff supervision policy.

**Proposed Timescale:** 24/11/2017