

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Ocean Crescent
Centre ID:	OSV-0005383
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Bernadette Donaghy
Lead inspector:	Anne Marie Byrne
Support inspector(s):	Ivan Cormican
Type of inspection	Unannounced
Number of residents on the date of inspection:	28
Number of vacancies on the date of inspection:	1

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 compliance with National Standards. 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:
03 April 2017 10:00	03 April 2017 20:00
04 April 2017 09:30	04 April 2017 15:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

Following a review of compliance across the Health Service Executive (HSE) CHO Area 1, the Health Information and Quality Authority (HIQA) raised concerns with the HSE National Director, in relation to the significant and on-going levels of non-compliance in centres operated by the HSE in CHO Area 1.

The Chief Inspector of Social Services required the HSE to submit a plan to the Authority which described the actions the HSE would take, in order to improve the quality of life for residents living in the services in CHO Area 1, the overall safety of the services operated by the HSE in that area and to improve and sustain a satisfactory level of compliance across the five core outcomes of concern.

In December 2016 the HSE submitted a governance plan to HIQA. The plan described the enhanced governance and leadership arrangements and actions that the HSE intended to take by 13 June 2017, in order to improve the overall levels of compliance and quality of life for residents in CHO Area 1.

In response to this plan, HIQA has developed a regulatory programme of inspections to verify the effectiveness of this plan in improving the quality of life for residents and to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with Disabilities Regulations

2013) (hereafter called the Regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the Standards).

How we gathered our evidence:

The inspectors met with 19 residents, eleven staff members and the person in charge during the inspection process. Some residents were able to communicate with the inspectors, with two residents speaking one-to-one with the inspectors. The centre is situated on a campus setting and consists of five houses, each house was visited by the inspectors.

Inspectors reviewed practices and documentation, including twelve residents' files, six staff files, incident reports, policies and procedures, fire management related documents and risk assessments.

Description of the service:

This centre is managed by the Health Service Executive (HSE) and is located on the HSE Cregg Services campus outside Sligo town. The centre provides residential services to people with an intellectual disability, who have been identified as requiring low to high levels of support. The service can accommodate male and female residents, from the age of 18 years upwards. At the time of inspection, all residents residing in the service were female. Two of the houses provide accommodation for seven female residents, two of the houses provide accommodation for five female residents and one house provides accommodation for four female residents. Four of the residents were identified for transition to the community later in the year.

The person in charge had overall responsibility for the centre. The person in charge is supported in his role by the provider. The person in charge works directly on the campus, in an administrative capacity, and regularly visits the centre's houses to meet with staff and residents. All houses are bungalows and have a communal kitchen, dining area, lounge and bedroom spaces for residents.

Overall judgment of our findings:

The provider had completed some of the actions from the previous inspection report from November 2015. However, significant improvements were required following this inspection. Inspectors found major non-compliance in all five outcomes inspected. These outcomes relate to social care needs, health, safety and risk management, safeguarding and safety management, governance and management and workforce.

An immediate action was issued to the provider due to significant concerns identified in relation the fire evacuation procedures and the calling of the fire brigade in the event of a fire in the centre. This was actioned by the provider and a written response to the immediate action has since been received by Health Information and Quality Authority (HIQA) outlining the actions taken to ensure that the issue would not reoccur.

The findings and their actions are further outlined in the body of the report and the action plan at the end of this 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 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:

Actions required from the previous inspection were not satisfactorily completed. Upon this inspection, improvements were required to the arrangements for meeting the assessed social care needs of residents and to the development of residents' personal goals.

Four residents were identified for transition to the community. Compatibility assessments had been completed for these residents and a process was in place to secure appropriate accommodation for them. The person in charge informed the inspectors that the centre planned to transition these residents to the community later in the year. However, there were no transition plans in place for these residents to guide on the support that these residents will require in preparation for transition.

At the time of inspection, the centre was in the process of reviewing residents' personal plans and personal goals. Personal goals had action plans in place to identify the nature of goals, those responsible for supporting the resident to achieve them and the timeframe in which goals were to be reviewed or achieved by. Staff reported that a new personal plan format was being implemented throughout the service and that it did enhance residents' involvement in personal plan development. However, the inspectors found inconsistencies in the development of personal goals. For example, some goals were comprehensively developed and detailed the support residents would need to achieve their goals. However, some of the goals did not reflect the progress made by residents towards achieving their goals, while some residents were found not to have any personal goals in place.

Staff who spoke with the inspectors during the inspection were very familiar with the residents, knowledgeable of their personal interests and of the social support needs required by them. Staff informed inspectors that some residents actively participated in day services, that some held employment and that some enjoyed getting out into the community to attend local amenities. Staff also reported to inspectors that some residents required increased staff support as they were of an aging population, while other residents required one-to-one nursing support at all times due to their neurological and nutritional care needs. However, staffing levels were found to be inadequate and did not meet the assessed needs of these residents. In one of the centre's houses, three out of five residents required one-to-one nursing support to engage in any social activity outside of the centre, with one staff nurse allocated to this house. Staff reported that this meant residents who required one-to-one nursing support for social activities were not supported to engage in activities outside the centre. Staff told the inspectors that this often meant that residents planned activities were cancelled due to limited staffing. Staff further reported that the centre was reliant on day-services to provide activities midweek, as the staffing arrangements within the centre at weekends did not facilitate bringing residents outside of the campus setting. One resident who spoke with the inspectors informed that her activities at the weekend were contained within the centre as she was aware there were insufficient staffing levels, in place at weekends, to bring her into Sligo town.

Inspectors met with residents who presented with cognitive impairments and with the staff who were caring for them. Staff informed inspectors that they are engaging in social care with these residents; however, this is occurring in an unstructured manner. Staff reported that some residents were spending long periods in the centre, with some only accessing the community once a month. The inspectors found there was no assessment or planned programme in place for residents with cognitive impairments to ensure the centre was appropriately meeting their social care needs.

The person charge informed the inspectors that an additional 39 hours of support was recently granted and was due to commence on the 7th of April 2017. The person in charge was in the process of identifying how these additional hours would be allocated for residents' social care at the time of inspection.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The actions required from the previous inspection were satisfactorily completed. Upon this inspection, inspectors found improvements were required to the fire management and risk management systems.

The provider had completed a number of fire drills across all houses and records of these were maintained. These records demonstrated that staff were able to evacuate all residents from the centre. However, the fire alarm was not being activated in all houses for drills, instead some houses used whistles to alert staff and residents of the fire drill. Staff informed inspectors that plans were in place to ensure all fire drills included the use of the fire alarm; however, staff were not aware as to when this would occur.

Although there was a fire alarm system in each of the centre's houses, the centre was reliant on staff on the main campus and in a separate centre to inform them on the location of the fire. The inspectors found some confusion between staff as to where the responsibility lay in informing the emergency services in the event of a fire. For instance, some staff informed inspectors that they would be required to contact the emergency services, while other staff informed the inspectors that staff from the main campus would contact the emergency services. Fire procedures were displayed in each of the centre's houses; however, staff were unable to demonstrate to the inspectors how they would be guided by these procedures in the event of a fire in the centre.

Personal emergency evacuation plans (PEEPs) were in place for residents and these were under review at the time of inspection. PEEPs included information about the level of support required by residents in the event of a fire. However, these evacuation plans did not consider the evacuation of residents from their bedrooms if the main emergency exits were inaccessible due to fire in the corridor of the house. In addition, where residents were at risk of absconding, the PEEPs did not describe the staff supervision and support that would be required by residents once they were at the assembly point. In addition, the inspectors also found there was some confusion between staff as to which fire assembly points they would evacuate residents to. Not all staff had received fire training at the time of inspection.

The centre had a system in place for the assessment, monitoring and review of resident and organisational risks. Staff spoken with had a good understanding of the role and function of residents' risk assessments and in how they informed care practices. Each house within the centre had its own risk register, which was updated monthly by nursing staff. However, inspectors identified the management of some organisational risks to be ineffective. For example, where risks were continually rated as high, there was no evidence that the effectiveness of control measures was being reviewed to determine why their implementation was continually having no impact on the risk rating. Inspectors also found that some residents' risk assessments did not identify the name of the resident that the risk was assessed for. Some gaps were also found in the assessment of residents presenting with neurological needs. Furthermore, there was a health and safety statement in place for the centre which was reviewed in January, 2017. This identified members of staff who were appointed as the health and safety representatives for the centre. The inspectors spoke with one of these staff members who was on duty on the day of the inspection. The staff member told the inspectors that

she no longer held this role and was not aware that she was still named as one of the appointed staff members for health and safety for the centre.

In two of the houses visited by inspectors, residents were found to be living in overcrowded accommodation. These houses each accommodated seven residents. Some residents in these houses presented with mobility needs and had visual impairments. Staff informed the inspectors that the number of residents being accommodated in these houses posed a risk to residents with mobility needs. In one instance, the inspector observed a resident requiring full-time staff supervision when mobilising, as the resident has difficulty in getting around the centre due to the movement of other residents residing in the same house. Although the centre had acknowledged the organisational risks posed by overcrowding in these houses, there was no assessment of the impact that this overcrowding had on individual residents living in the centre.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The actions from the centre's previous inspection report were not satisfactorily completed. Inspectors found significant gaps continued in providing staff with up-to-date training in the management of behaviours that challenge. Improvements were also required to the appropriate application of restrictive practices.

Some residents presented with behaviour that challenges in the centre, and these residents were supported, through regular review, by a behavioural support specialist. Behavioural support plans were in place for these residents to inform staff on how to respond and manage residents' specific behaviours. However, inspectors found staff had still not received up-to-date training in the management of behaviour that challenges, which had been identified as a failing during the last inspection of the centre.

Restrictive practices were in place, with some houses having locked kitchen cupboards.

Staff reported to the inspectors that these cupboards were not always locked, but when they were it was to safeguard residents who were identified at risk of choking. Staff were able to inform the inspectors as to when this restrictive practice was to be applied. However, there was no documentation in place to support the application of this environmental restriction. Similarly, where residents were prescribed 'as required' chemical restraints, there was no guidance in place to inform staff on its appropriate application and administration.

There were safeguarding plans in place at the time of inspection and staff demonstrated to inspectors their understanding of their role in the reporting of any safeguarding concern. However, inspectors found not all measures had been undertaken by the provider to safeguard residents. For instance, following a preliminary screening of a peer-on-peer incident, recommendations were made to the provider to conduct compatibility assessments in order to assess the suitability of these residents living with each other in the same house. However, inspectors found the provider had failed to inform the safeguarding officer of compatibility concerns identified as part of these assessments. In addition, not all staff had received up-to-date safeguarding training at the time of inspection.

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:

Leadership, Governance and Management

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

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

Findings:

Actions required from the previous inspection were satisfactorily completed. However, significant improvements were required following this inspection in relation to the governance and management arrangements of the centre.

The person in charge had the overall responsibility for the centre and was supported in his role by the provider. Inspectors met with the person in charge who was appointed to the role in January 2017. He has previous experience in managing centres, is suitably qualified and demonstrated a clear understanding of his role and legislative

responsibility. The person in charge was based on the campus setting and staff were familiar with him. However the person in charge was also responsible for the running of four other centres, which provide care and support to 95 residents in total. At the time of inspection, the person in charge was relying on nursing staff to support him in the day to day management of each house in the centre. The person in charge also held the role of safeguarding officer and acting director of nursing for the campus setting. The person in charge informed the inspectors that currently his role of person in charge is challenged given the external demands and constraints of his role. The provider and person in charge informed the inspectors that plans were in place to reconfigure the size and management arrangements for the centre; however, no timeframe for when this would be commencing was identified.

There was evidence that some governance and management systems were in place. However, the oversight of these governance and management systems was ineffective. The centre had a number of action plans in place, including those developed from the findings of unannounced provider visits, the annual service review, quality improvement audits, the last HIQA inspection report and a plan for remedial works. Inspectors reviewed these action plans and found a number of deadlines for the completion of actions were not achieved, with no evidence of review by management for when overdue actions might be brought back into achievable timeframes. For example, a review of the centre's annual service review demonstrated poor deadline achievement with five out of 18 actions overdue. The centre's plan for remedial works identified 32 action areas, two of which were completed, but this action plan did not guide on when the centre expected to complete the remaining 30 action areas.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Actions from the centre's previous inspection report had not been satisfactorily completed. Improvements required remained in relation to staff training and the maintenance of Schedule 2 documents. Improvements were also required to the

maintenance of staff rosters.

Planned and actual staff rosters were available in each house of the centre. These showed the start and finish time of staff on duty during the day and night. However, inspectors found some dates did not indicate what staff were on duty. This was brought to the attention of a staff nurse on duty who was required to refer to residents nursing notes to inform inspectors of which staff member was rostered on the dates selected. In addition, where additional staff support was provided to some houses in the centre, the name and hours worked by the additional staff members was not always recorded in the roster.

There were inadequate staffing levels to meet the social care needs of residents. In addition, the centre was no longer allocated housekeeping staff and care staff were now assigned the role of completing housekeeping duties. Management were unable to inform inspectors how many care hours were now being re-directed to housekeeping duties. Staff informed the inspectors that they did not have sufficient capacity to meet the needs of residents in the centre and effectively carry out the housekeeping of the houses.

Staff supervision had commenced for the centre; however, the last recorded supervision was in August 2016. There was a record maintained of staff who had received supervision during this time; however, there was no plan in place for when the remaining staff members would be supervised. Systems were in place to provide staff with refresher training; however, not all staff had received up-to-date training in manual handling.

Not all schedule 2 documents were maintained by the centre.

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:

Anne Marie Byrne
Inspector of Social Services
Regulation Directorate

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005383
Date of Inspection:	03 April 2017
Date of response:	26 May 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 05: Social Care Needs

Theme: Effective Services

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

The provider failed to ensure personal plans and personal goals were available to all residents in an accessible format.

1. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are

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

made available in an accessible format to the residents and, where appropriate, their representatives.

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

All residents' personal plans are made available in an accessible format to all residents and, where appropriate, their representatives.

Proposed Timescale: 26/04/2017

Theme: Effective Services

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

The provider failed to ensure all residents had personal plans in place

2. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

The provider has ensured that all residents have personal plans in place.

Proposed Timescale: 28/04/2017

Theme: Effective Services

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

The provider failed to put in place arrangements to meet the assessed needs of residents to include:

- residents assessed with requiring one-to-one support for social care
- social care arrangements for residents assessed with a cognitive impairment

3. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

The provider has made arrangements for an additional 39 hours to support residents to access their local community and participate in social activities as per social care needs assessment. An evaluation of the additional support hours will be conducted within a six week period, this will determine any additional 1:1 support hours that may be required which will then be actioned.

All residents with cognitive impairment now have a holistic assessment of need completed which informs staff how the social care needs of each resident are to be met.

Proposed Timescale: 07/06/2017

Theme: Effective Services

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

The provider failed to ensure plans were in place to guide on the supports required for residents as they plan to transition from the centre.

4. Action Required:

Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

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

The provider will ensure plans will be in place to guide on the supports required for residents as they plan to transition from the centre to their new home in the community by the below date.

Proposed Timescale: 23/06/2017

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:

The provider failed to put in place systems for the assessment, management and on-going review of risk to include:

- ensuring risk assessments identify the resident for which the risk has been assessed
- where risks are continually rated as high, the effectiveness of control measures is reviewed
- adequate control measures are put in place for residents residing in overcrowded houses.
- risk assessments completed for residents presenting with neurological needs.
- staff are aware of their role and responsibility for health and safety in the centre

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:

The provider will ensure that existing risk management systems are currently being reviewed within the designated centre. The assessment, management and on-going review of risks, including a clear plan for responding to emergencies will now be

included in the overall system. This will be completed for all houses under this designated centre by the below date.

- The provider will ensure that all risk assessments will identify the residents for which the risk has been assessed.
- The provider will ensure that all risk assessments will be reviewed to ensure the control measures that are in place are effective.
- The provider will ensure that effective control measures are in place to address residents residing in overcrowded houses by taking the following actions;
 - All residents positive behaviour support plans will be reviewed and updated by the below date.
 - All residents also have Formal Safeguarding plans in place in consultation with the safeguarding team.
- The provider has ensured that all residents presenting with neurological needs have individual risk assessments completed.
- The provider has ensured that all staff are aware of their role and responsibility for health and safety in the centre. A new Health and Safety system has been introduced and training on this system has been provided.

Proposed Timescale: 23/05/2017

Theme: Effective Services

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

The provider failed to ensure all staff had up-to-date fire training.

6. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

The provider will ensure all staff have up-to-date fire training, training dates have been scheduled for 19/05/2017.

Proposed Timescale: 19/05/2017

Theme: Effective Services

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

The provider failed to ensure all staff were aware of their role and responsibility for informing emergency services in the event of a fire

7. Action Required:

Under Regulation 28 (3) (c) you are required to: Make adequate arrangements for

calling the fire service.

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

The National HSE Fire Action notice has being updated in conjunction with the HSE Fire Officer following a meeting on the 20/04/2017 with all team leaders in Ocean's Crescent. This Fire Notice clearly lays out, that Fire Service is contacted by the team lead on duty on any day/night. All members of staff have been informed by team leads of same with immediate effect. The Fire Policy has being updated to take into consideration these changes. The weekly meeting with the Team Manager will have on the agenda the Fire action notices so it is brought to the attention of all staff & Monthly Fire Drills will continue be carried out and documented in Fire Register. This 1 page National Fire Action Notice is the Fire Procedures in place going forward.

Meeting held with HSE Fire Officer on the 20/4/2017, Team Manager & Unit Leads to prioritise the 1 Page Fire Action Notices that will be followed across Oceans Crescent. This is displayed across all bungalows within this designated team for staff to follow. Clear guidelines are laid out in relation to evacuation procedures. The weekly meeting with the Team Manager will have on the agenda the Fire action notices so it is brought to the attention of all staff & Monthly Fire Drills will continue be carried out and documented in Fire Register.

The HSE Fire Action Notices clearly outlines the Fire Assembly point that are clear & concise for staff to follow. All members of staff have been informed by team leads of same with immediate effect. These notices are displayed in all areas across this designated centre.

The provider has ensured that all staff are aware of their role and responsibility for informing emergency services in the event of a fire. This is demonstrated in successful fire drills showing staffs knowledge in relation to informing the emergency services. Fire drills are documented in the fire risk register.

Proposed Timescale: 22/04/2017

Theme: Effective Services

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

The provider failed to put in place adequate fire management systems in relation to:

- Clear fire procedures to guide staff on what to do in the event of a fire
- The use of fire alarm system as part of fire drills
- Clarity on the assembly points to be used in the event of a fire

8. Action Required:

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

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

The National HSE Fire Action notice has being updated in conjunction with the HSE Fire Officer following a meeting on the 20/4/2017 with all team leaders in Ocean's Crescent.

This Fire Notice clearly lays out, that Fire Service is contacted by the team lead on duty on any day/night. All members of staff have been informed by team leads of same with immediate effect. The Fire Policy has being updated to take into consideration these changes. The weekly meeting with the Team Manager will have on the agenda the Fire action notices so it is brought to the attention of all staff & Monthly Fire Drills will continue be carried out and documented in Fire Register. This 1 page National Fire Action Notice is the Fire Procedures in place going forward.

Meeting held with HSE Fire Officer on the 20/4/2017, Team Manager & Unit Leads to prioritise the 1 Page Fire Action Notices that will be followed across Oceans Crescent. This is displayed across all bungalows within this designated team for staff to follow. Clear guidelines are layed out in relation to evacuation procedures. The weekly meeting with the Team Manager will have on the agenda the Fire action notices so it is brought to the attention of all staff & Monthly Fire Drills will continue be carried out.

The fire alarm system are been used as part of the fire drills and this will be documented in Fire Register.

The HSE Fire Action Notices clearly outlines the Fire Assembly point that is clear & concise for staff to follow. All members of staff have been informed by team leads of same with immediate effect. These notices are displayed in all areas across this designated centre.

Proposed Timescale: 22/04/2017

Theme: Effective Services

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

The provider failed to ensure personal evacuation plans identified the arrangements for the evacuation of residents from bedrooms.

9. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

The provider has ensured that personal evacuation plans identify the arrangements for evacuation of residents from bedrooms.

Proposed Timescale: 20/04/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

The provider failed to ensure guidance documents were available to staff on the appropriate application of environmental restrictive practices in accordance with national policy and evidenced based practice.

10. Action Required:

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

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

The Provider has ensured protocols relating to appropriate application of environmental restrictive practices have been developed by Senior Psychologist in consultation with staff in relevant areas. All will be complete by the below date:

Proposed Timescale: 16/05/2017

Theme: Safe Services

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

The provider failed to ensure all staff had received up-to-date training in the management of behaviour that challenges.

11. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

The provider will ensure that all staff have received up-to-date training in the management of behaviours that challenge. This will be completed by the below date:

Proposed Timescale: 30/06/2017

Theme: Safe Services

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

The provider failed to ensure all staff had received up-to-date training in safeguarding

12. 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:

The provider will ensure that all staff will have received up-to-date training in safeguarding by the below date.

Proposed Timescale: 31/05/2017

Theme: Safe Services

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

The provider failed to ensure that appropriate action was taken following the review of a safeguarding concern.

13. 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:

The Provider has ensured that appropriate actions have been taken following a review of the Safeguarding concern. Preliminary Screening was carried out and Compatibility Assessment completed. Formal Safeguarding plan is in place. A strategy meeting to be held with the Social Worker by below date.

Proposed Timescale: 19/05/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The provider failed to ensure that the person in charge was adequately supported to effectively govern and manage the centre.

14. Action Required:

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

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

The Provider will ensure that the management and governance structures will be strengthened in this Designated Centre. The PIC will be supported in their management role by 2 managers (1 CNM2 and 1 CNM1). The CNM2 will have responsibility for 3 areas and the CNM1 will have responsibility for 2 areas in a supernumerary capacity. This will be operationalized by the below date:

Proposed Timescale: 18/05/2017

Theme: Leadership, Governance and Management

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

The provider failed to put management systems in place in the centre to ensure that the service provided is consistent and effectively monitored in relation to the management of deadline achievement.

15. 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 will ensure that the management and governance structures will be strengthened. This designated centre will be managed by 2 managers (1 CNM2 and 1 CNM1). The CNM2 will have responsibility for 3 areas and the CNM1 will have responsibility for 2 areas in a supernumerary capacity. This will be operationalized by the below date. This management and governance structure will be responsible for the monitoring and management of all deadline achievements.

Proposed Timescale: 18/05/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The provider failed to ensure that the number of staff working in the centre was appropriate to the assessed needs of residents.

16. 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 Provider will ensure a staffing review will be undertaken to ascertain the appropriate skill mix is in place to meet the identified needs of residents. Following this review the Provider will ensure the appropriate number of staff will be in place in this designated centre. This will be completed by the below date.

Proposed Timescale: 31/05/2017

Theme: Responsive Workforce

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

The provider failed to ensure a planned and actual staff roster showing staff on duty was maintained at all times.

17. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

The Provider has ensured that a planned and actual staff roster showing staff on duty is in place.

Proposed Timescale: 07/04/2017

Theme: Responsive Workforce

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

The provider failed to ensure all documents as outlined in Schedule 2 of the regulations were maintained for all staff working in the centre.

18. 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 Provider will ensure information and documents as specified in Schedule 2 will be obtained for all staff working within the designated centre by the below date.

Proposed Timescale: 30/06/2017

Theme: Responsive Workforce

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

The provider failed to ensure staff were appropriately supervised to their role

19. 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 Provider has ensured a planned schedule for supervision of all staff within this

designated centre is in place. Supervision will be completed with all staff by the below date.

Proposed Timescale: 15/06/2017

Theme: Responsive Workforce

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

The provider failed to ensure all staff had up-to-date training in manual handling.

20. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

The provider will ensure all staff have received up-to-date training in manual handling by the below date.

Proposed Timescale: 09/06/2017