Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Centre A2
Centre ID:	OSV-0005387
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Peamount Healthcare
Provider Nominee:	Suzanne Corcoran
Lead inspector:	Anna Doyle
Support inspector(s):	Conan O Hara Day Two only
Type of inspection	Announced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 April 2017 09:30	12 April 2017 20:00
13 April 2017 08:00	13 April 2017 15:40

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection.
This was the second inspection of the designated centre as a standalone centre. Prior to the last inspection the centre had been part of a larger designated centre which the provider had reconfigured.

As part of the application to register the centre, the provider was required to submit relevant documents, which were all submitted at the time of that inspection.
The last inspection was carried out in June 2016. Since then the provider had submitted an application to reduce the capacity of the centre from 18 to 16

residents. One form was required to be submitted in relation to this application and the provider agreed to submit this information after this inspection.

At the last inspection significant failings were found under the regulations and the provider attended a meeting in HIQA's Dublin office to discuss these findings and to offer assurances to HIQA that these failings would be addressed.

Due to major renovation works being completed in the centre, the registration inspection was rescheduled on two occasions to facilitate this work.

This inspection was announced and took place over two days. A second inspector was present on day two of the inspection and one member of HIQA personnel was also present to observe practice. Their presence had been agreed with the provider and the person in charge prior to the inspection taking place.

Description of the service.
The centre is operated by Peamount Healthcare and is situated in a campus based setting in County Dublin. The centre consists of four units and caters for male and female residents, some of whom require supports in healthcare and mobility issues. The care and supports provided by the centre were outlined in the statement of purpose for the centre. Care is delivered by nursing staff and healthcare assistants in the centre.

How the inspector gathered evidence.
The inspectors met all of the residents residing in the centre and spoke with a number of residents in line with their personal choice. Staff and family members were met.

The inspectors also observed practice, for example, meals being served, staff interactions with residents and the provision of activities. Documentation including, policies and procedures, personal plans, residents financial records, fire safety records, staff rosters and staff training records were reviewed. All of the units were visited by the inspectors.

Overall judgment of findings.
Overall inspectors found that the quality and safety of care and support were monitored on an ongoing basis by the provider but that the measures in place to address the actions from these were not fully implemented and this was contributing to a lot of the failings identified at this inspection.
Good practices were identified in the provision of healthcare and residents' healthcare needs were appropriately met in a timely manner.

The inspectors found that residents were observed to be happy living in the centre. Residents said that they liked the staff working in the centre and staff were observed to have a good rapport with residents over the course of the inspection.

The units in the centre had recently been renovated and this had required significant changes for residents in the centre. These changes involved a considerable amount of work. Inspectors acknowledge that given the time frames since the works were

completed that the centre was finished to a high standard on the day of the inspection, contributing to a homely environment for residents.

One major noncompliance was identified in relation to operational procedures for the management of medication. Five outcomes were found to be in moderate compliance. These included outcome 1: residents rights dignity and consultation; outcome 5: social care needs; outcome 8 safeguarding and safety; outcome 14 governance and management and outcome 17; workforce.

Two outcomes were found to be in substantial compliance with the regulations under outcome 6: safe and suitable premises and outcome 18: records and documentation. The remaining eight outcomes were found to be compliant.
The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in 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 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Overall, the inspectors found that residents were for the most part consulted about their care in the centre. However, improvements were required in this area and respecting residents' rights and privacy in the centre.

Residents were consulted on how the centre was run through monthly residents meetings. From the records viewed inspectors found that discussions took place around recent events, upcoming activities and actions had been identified to follow up on. In addition, the residents were consulted through the campus wide "speak up advocacy" group.

The inspectors observed staff seeking residents' views and respecting residents' choices about their routine and preferences. However, it was not evident that residents were consulted about the choice of recently purchased beds for the centre and whether they were for the assessed needs of residents.

There was a complaints policy in place and information on the complaints process was on display in a prominent area in the centre. Inspectors reviewed a sample of complaints and found that complaints were followed up and the satisfaction of the complainant was recorded. Residents had access to advocacy services, the details of which were on display in the centre. Family members said they could raise concerns with staff and that issues were dealt with appropriately.

Inspectors observed staff treating residents with respect and dignity at all times over the course of the inspection. However, language used in some of the documents pertaining

to residents care was not respectful. The inspectors acknowledge that this was not evident in most of the records stored. This was discussed at the feedback meeting.

The inspectors reviewed residents' finances and found that there were appropriate practices in place for the management of residents' finances. However, residents were being charged different amounts for services provided in the centre as outlined in their contracts of care. The inspectors found that this was not respecting residents' rights in the centre as in some instances residents were receiving the same services but were being charged more fees.

The location of the central office of the designated centre in one of the units was not respecting residents' rights to privacy. This had been raised as an issue at the last unannounced quality and safety review of the centre, staff had raised it as a concern in their supervision and it was observed over the course of the inspection to be impacting on the privacy of residents. While inspectors were informed that this had been reviewed by the provider and that some measures had been taken to address this, the level of disruption was still considerable to residents in the centre as observed by inspectors.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Overall the inspectors found that residents' communication needs were met and supports were provided to residents as required.

The centre had a policy on communication. Individual communication needs were highlighted in residents' plans and in communication passports. Staff spoken with were aware of the different communication needs of residents.

The inspectors reviewed a sample of residents' communication passports which had been developed by the speech and language therapist and staff. They detailed resident's ability to communicate, ways in which they liked to communicate, likes and dislikes and people important to them in their lives.

Inspectors observed communication aids in use in the centre to support residents. For example, picture menus, activity boards and picture schedules were in place.

Residents had access to phones, radio, and television. Internet access was available in three of the units in the centre and inspectors were shown records to demonstrate that this would be completed for the fourth unit in the coming weeks.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
The inspectors found that residents were supported to develop and maintain positive personal relationships and develop links with the wider community.

The centre had a visitor's policy in place. Staff and families spoken to said that there are no restrictions on visits to the centre.

Residents spoke about family contact and one resident was going on a break to family members on the day of the inspection.

The inspectors reviewed records of contact with friends and family and found that residents maintained regular contact through phone calls, visits to the centre and visits home. Families said that they were kept informed of resident's wellbeing in the centre and were consulted with as part of residents' annual reviews.

However, they felt that some decisions recently made by the provider had not been discussed in a timely manner with them or their family member. Inspectors viewed records where this had been acknowledged by the person in charge and had been followed up.

Residents were supported to maintain links with the community based on their individual choices. Residents were engaged in day services and involved in shopping, day trips and dining out.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
The inspectors found that there was an admission policy in place in the centre and that residents had contracts of care in place that set out the fees to be charged and the services provided.

There were written contracts in place for residents outlining the services to be provided and the fees to be charged. The contracts had been sent to residents' representatives where appropriate and some of them were yet to be returned to the interim person in charge.

There had been no new admissions to the centre since the last inspection and inspectors were informed that Peamount Healthcare are not accepting admissions to the centre from external sources.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The inspectors found that improvements had been made in a number of areas since the last inspection. However, improvements were still required in the review of personal plans, the progression and development of goals for some residents and also to ensure that all residents social care needs were being met in the centre.

Each resident had a personal plan in place that included an assessment of need for each resident. A meaningful activities report had been completed by an occupational therapist for residents that detailed their preferences for activities.

Support plans were in place for residents healthcare needs that detailed the supports required. These were reviewed every three months by nursing staff. However, other reviews by allied health care professional were not always included in their personal plans in order to guide practice.

An annual review had been completed for all residents which included consultation with the resident and their representatives where appropriate. From this review; goals had been identified under specific themes. Inspectors found that some goals had actions identified and the progression of goals had been recorded for residents.

However, some identified goals did not have this included. For example, one resident's goal was to purchase knitting needles and wool, and it was not recorded how this goal would progress for the resident.

Multidisciplinary meetings were held regularly to review residents care in the centre. The minutes viewed by inspectors did not demonstrate how this review was improving outcomes for residents. Inspectors acknowledge that this process is being changed by the provider as part of a wider service improvement plan.

Aspects of personal plans were made into an accessible format for residents. This included activity schedules and parts of the annual review for residents. Residents also had communication passports in place that detailed their likes and dislikes and some of their support needs.

Inspectors found that some improvements had been made so as to meet residents' social care needs in the centre. For example residents were observed on the day of the inspection going out for supper, one resident was being supported to join a local social community group. Other residents spoke about going on holidays, going shopping, attending day services and a recent party they had attended.

However, inspectors found that some residents still had limited meaningful activities during the day. For example, one residents plan recorded 26 activities in total from August 2016 to date of the inspection. Another resident was observed to have completed five activities in a one month period. This included activities in the centre and external to the centre.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The inspectors found that the location, design and layout of the centre were suitable for its stated purpose. The centre was generally very clean and well maintained. However, improvements were required in one area.

Three of the units in the centre had been updated since the last inspection. Part of this update included reconfiguring premises to ensure that residents had their own bedrooms and that suitable showering facilities were available in the centre to meet residents needs.

Inspectors found that these units were clean, suitably maintained and tastefully decorated. However, the kitchen in one unit required repair due to a burnt counter-top and a dirty and damaged cooker hob.

Residents' bedrooms were decorated with personal items belonging to them. One resident showed inspectors a chest of drawers in their room that they had decorated themselves. Rooms were of an adequate size and there was adequate storage for residents' personal belongings.

There were enough toilets and shower facilities to meet the residents' needs in the centre and assistive equipment was available as appropriate.

There was a kitchen that had cooking facilities available to residents. Adequate communal space was available in the centre and residents had their own bedrooms should they wish to meet family or friends in private.

Residents' clothes were laundered in a central laundry on the campus. However, facilities were provided in the units should residents wish to launder their own clothes.

There were systems in place to ensure that clinical and general waste was disposed of appropriately.

Maintenance records of equipment used in the centre were stored in the maintenance department on the campus. The maintenance manager had oversight over these

records. From a sample viewed, inspectors found that they were up to date.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
Overall the inspectors found that there were systems in place to protect the health and safety of residents, visitors and staff in the centre. However, these systems were not always effectively implemented and significant improvements were required in a number of areas.

There was risk management policy in place which had been updated since the last inspection to include the requirements under the regulations.

Since the last inspection the provider had employed additional staffing to mitigate the risk identified at the last inspection regarding residents who were unsupervised for periods of time in the centre.

Residents had individual risk assessments completed that were subject to a regular review. However, they were set out on the risk register which was stored on the computer and not on resident's plans. Inspectors found that agency staff did not have access to this information in the centre in order to guide their practice.

In addition, there was no plan in place to outline the control measures in place for one resident who had been assessed as a high risk of falls.

Inspectors also found that some risk adverse practices were in place in the centre. For example, some residents required nursing support in the community due to their assessed needs. This had not been appropriately assessed to endeavour to mitigate risks to residents.

There were systems in place to review incidents in the centre. From the sample viewed inspectors found that this had only commenced in the centre since December 2016. The review was detailed in that it identified trends and any further control measures required.

However, inspectors found that the control measures identified were not always implemented into practice. For example one incident review recommended that staff allocated to support a resident should be trained and familiar to the resident and this was not consistently implemented. Inspectors found that this resident was being supported some days by unfamiliar staff who were not trained in a specified area.

In addition, it was not clear how this information was communicated back to staff to inform practice as no regular meetings were held in the centre. Both of these failings had been identified at the last inspection.

Fire safety procedures were displayed in the centre. All staff had completed fire safety training with the exception of one, but there was a plan in place to address this.

There was an emergency plan in place which included the location where residents should be evacuated to in such an event.

Residents had personal emergency evacuation procedures in place. However, some improvements were required in one resident's plan that was at risk of wandering. The plan did not include the supports required for this resident in the event of an evacuation of the centre.

Staff spoken with were clear about the procedures in place. Fire drills had been completed in the centre since the last inspection. From the records viewed inspectors found that evacuations were completed in a timely manner. However, there were no records to demonstrate how issues identified at one fire drill had been responded to so as to review and inform future fire drills.

Fire equipment was in place for the containment of fire and the records viewed indicated that this equipment was maintained appropriately. Fire doors were in place in the centre.

Effective systems were in place around infection control practices in the centre.

A number of vehicles were used for the transportation of residents. The records indicated that they were roadworthy and insured.

Judgment:
Non Compliant - Moderate

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:
Overall inspectors found that there were systems in place to protect residents being harmed in the centre. However, improvements were still required in behaviour support plans and restrictive practices in the centre as highlighted from the last inspection.

There was a safeguarding policy available in the centre. All staff had received training in this area. Staff spoken with were knowledgeable about what constitutes abuse and the procedures to follow in such an event. Residents spoken to said they felt safe in the centre and were observed to be comfortable in their surroundings.

Appropriate reporting procedures were implemented by staff regarding incidents where the impact of some individual behaviours on others had occurred in the centre. However, recommendations from a review of these incidents were not always implemented. For example, records indicated that a team meeting should be scheduled to review an incident and this had not been completed.

The policy on the use of restrictive practices in the centre required review. Inspectors found that some improvements had been made in this area since the last inspection. Restrictive practices were now being reviewed. However, the records did not demonstrate what alternatives had been considered if any so as to ensure that the least restrictive practice was being used.

In addition, inspectors also observed that some presses in the centre were locked and there was no clear rationale for this when inspectors asked staff. This practice was stopped on the first day of the inspection.

There was a policy in place on the provision of behaviour support. Four staff were not trained in challenging behaviour and a restraint intervention. From a sample of behaviour support plans viewed inspectors found that the information did not guide practice for staff and did not always reflect the actual practices in place to support residents. For example, one plan stated that "a resident should be supervised all of the time as much as possible".

While inspectors found that staff spoken to were knowledgeable about residents support needs in this area, a significant number of agency staff were employed in the centre on a weekly basis and therefore these plans would not guide their practice.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
Overall the inspectors found that a record of all incidents occurring in the centre were maintained and where required notified to HIQA.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
The inspectors found that residents had some opportunities for new experiences in the centre.

There was a policy in place on access to education, training and development in the centre. Residents met spoke about some activities they were involved in both internal and external to the centre. Residents attended a day centre on the campus. Attendance to this was on a session basis. One resident attended a community group.

On the days of the inspection some residents were out for lunch. One resident had recently taken part in a fundraising event for a national charity organisation. Another resident had a life skills teaching certificate of attendance displayed in their room.

However, as discussed in Outcome 5 of this report improvements were required so as to ensure that residents were engaged in activities on a more consistent basis.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
The inspectors found that residents were supported to achieve best possible health in the centre.

Each resident had a healthcare assessment of need contained in their personal plan that outlined the care and support required in order to meet those needs. Staff spoken to were clear about residents needs.

Residents had regular access to allied health professionals in the centre which included behaviour nurse specialists, physiotherapists, speech and language and occupational therapists.

A medical practitioner who was known to the residents visited the centre twice weekly.

Meals were provided from a central kitchen on the campus. Inspectors found that residents could choose their meal preferences on a daily basis. A number of mealtimes were observed over the course of the inspection. Inspectors found that residents were supervised appropriately and that time was afforded to residents during mealtimes to ensure that they were happy with the meals provided and alternatives were observed being offered to residents.

Snacks and refreshments were available for residents in the centre and residents were observed being offered these by staff between meals.

One resident was supported to prepare their own meals with staff support. Inspectors also observed from records viewed that residents were supported to bake in the centre.

Judgment:
Compliant

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

Findings:
Overall the inspectors found while the centre had a policy and procedures on medication management, improvements were required in self administration assessments, documentation and recording practices, administration practices in the centre and in the policy relating to the administration of as required (p.r.n.) medication.

The designated centre's policy and procedures for medication management was not clear with regards to the administration of p.r.n. medications. There were no completed p.r.n. protocols on file to guide staff practice. This had been an action from the last inspection. Also staff who were not authorised to administer medication were unsure of when to seek the assistance of authorised staff for some prescribed medications. The inspectors found ambiguity in the designated centre's policy and procedures on medication management in the area of p.r.n. administration with conflicting statements made regarding who was authorised to administer the medications.

The self administration of medication assessments were a requirement as per the designated centre's policy and procedures on medication management, however, no files reviewed had assessments available and staff confirmed that these had not been completed. One resident expressed a wish to administer their own medications and stated that current practices in this area restricted social activities on occasions.

Staff administering medications had a good knowledge of the content of the designated centre's policy and procedures on medication management; however, there were some concerns in relation to documentation and recording practices. Signature banks had not been completed by all staff administering medications and only five staff members had signed to confirm that they had read the policy and procedures relating to medication management. Inspectors also found that not all medications were signed for by the administering staff member.

For example, some prescribed topical creams which are also over the counter products were not being administered by the nurse who had signed the administration sheet. This was highlighted to the clinic nurse manager who reported it to the pharmacist on the second day of the inspection. This was not in line with best practice as was recognised at the feedback meeting by staff present.

In addition, to this some prescribed medications did not have the prescriber's registration number listed as required by the designated centre's policy and procedures for medication management.

A review of recent audits showed that a senior pharmacist had completed a medication audit of the designated centre. In addition to this a separate audit was completed by a member of the management team. The findings from this found that some administration errors were occurring in the centre which had not been recorded as a medication error.

Medication administration plans were available for residents in an accessible format.

Appropriate procedures were in place for the storage and disposal of unused medications. No controlled medications were prescribed in the centre.

A fridge was available for medications that required storage.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
Overall the inspectors found that the statement of purpose for the designated centre contained the majority of information required under the regulations. Some minor amendments were required and the person in charge agreed to submit the updated statement of purpose with these changes to HIQA within one week of the inspection date. This was submitted.

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

Findings:
Overall inspectors found that there were management structures in place that identified lines of accountability. However, improvements were still required so as to ensure that the actions identified from the mechanisms in place to review and audit the quality of services provided in the centre were fully implemented and overseen by identified personnel.

Since the last inspection there had been a number of changes in the governance and management structures of the centre. As part of the last action plan the provider had agreed to review the role of the person in charge in the centre so as to ensure effective governance. This included the appointment of a new person in charge.

However, the person who had taken up the role had since left and there was a period of months where effective governance structures were not in place in the centre. In response a new person in charge had been appointed earlier this year.

They were present on the day of the inspection. They were found to be suitably qualified and knowledgeable of the regulations. However, the person in charge was also the director of rehabilitation for the campus and inspectors were informed that the provider was currently recruiting for this role.

As an additional measure the provider had redeployed two staff to the centre in January 2017 to assist the person in charge with their role. Both of these staff were supernumerary in their roles and were found to be very knowledgeable of the residents' needs and the requirements under the regulations.

One of these staff was a clinic nurse manager and they had managerial responsibilities assigned to them. For example, they had oversight over the delivery of care on a day to day basis in the centre. They reported directly to the person in charge and said that they had regular contact with them on a daily basis.

Staff said they felt supported in their role since the appointment of the new person in charge and the additional supernumerary staff deployed to the centre. Staff received supervision in the centre. However, staff meetings were not regularly held in the centre.

An unannounced quality and safety review had been completed in the centre in October 2016. Areas of improvement had been identified from this. However, some actions had not been implemented and were still ongoing in the centre. For example, residents requiring support from nurses while out in the community, the situation of the office in

one unit which was impacting on residents and the development of medication protocols which were still not in place at the time of this inspection.

An annual review had been completed for 2016. However, it did not include the views of residents or their representatives. Actions had been identified from this review, however some of these had not been fully implemented and there were no records to demonstrate how these actions were progressing.

The inspectors found that while there were a number of measures in place to monitor the quality of care in the centre, a number of actions had not been fully implemented and there was a lack of oversight for the completion of these actions so as to improve the quality of services in the centre.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
The inspectors found that the provider was aware of their responsibility to notify HIQA of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the centre during their absence.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

No actions were required from the previous inspection.

Findings:
The inspectors found that the centre was adequately resourced to meet residents needs. But as outlined in this report under outcome 5 and 17 additional resources were required to ensure that sufficient staff are present to meet residents social care needs in the centre.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Overall inspectors found that the staffing levels in the centre had improved since the last inspection. However, improvements were required in one unit of the centre to ensure that appropriate staff numbers were present to support residents needs during specified times.

Since the last inspection the provider had reviewed the staffing levels in the centre. This had been completed by an external agency. The inspectors found some of the recommendations from this had been implemented. For example, an additional staff nurse was now on duty every day in order to meet residents needs. A "float" staff was now employed from eight to six every day to support staff in units to meet residents' needs as required. One resident was now being provided with one to one support every day.

However, improvements were still required in one unit as inspectors found that this unit did not have sufficient staff to meet residents' needs in timely manner, particularly in the morning time. For example, one staff was observed to be supporting six residents on the second day of the inspection. Supports included the supervision of meals, assisting with personal care which required one to one support. Staff confirmed that some mornings this could be extremely difficult as three residents with mobility issues needed supports to leave for the day services at 9.30am.

Staff spoken with in other units felt that there was adequate staff available to meet residents needs since the additional staff had been employed. However, some spoken with felt that additional staffing was required some days so as to meet residents' social care needs. Inspectors acknowledge that the provider has plans in place to address this.

Supervision was in place for staff. This was completed by the person in charge and the clinical nurse manger in the centre. Four staff are still to have this completed. Records viewed by inspectors found that staff could raise concerns and other issues such as training needs were discussed.

There was a planned and actual staff rota in place that demonstrated the hours worked by staff members. This had been an action from the last inspection.

Inspectors found that there was a significant number of agency staff employed in the centre. For example 160 hours agency were required on one rota viewed by inspectors. However, the provider was taking steps to address this. For example, to improve consistency of care regular agency were employed where possible, the provider was currently recruiting a regular relief panel for the centre and some relief had already commenced in the centre.

Training records viewed found that some staff had completed mandatory training in safeguarding, manual handling and fire safety.
Inspectors also observed training session memos for epilepsy and diabetes for staff, which was currently being rolled out for staff.

Personnel files were viewed by inspectors at an earlier date to the inspection and were found to contain the requirements as set out in the regulations.

Records made available to inspectors demonstrated that agency staff were Garda vetted and had completed mandatory training.

There were no volunteers employed in the centre.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Overall, the inspectors found that the documentation required by the regulations were maintained in the centre. However, some improvements were required.

The inspectors reviewed the directory of residents and found that it did not contain all of the information required by Schedule 3 including marital status, next of kin address, GP details.

A resident's guide was maintained in the centre which included all information required under Regulation 20.

The inspector found that the records kept in the designated centre were in accordance with Schedule 4.

The policies and procedures as required by Schedule 5 of the regulations were in place. However, the inspectors found that two polices had not been reviewed in line with timeframes specified in the regulations. These included:

- The policy on restrictive practice.
- The policy on nutritional intake.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Anna Doyle
Inspector of Social Services
Regulation Directorate

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Peamount Healthcare
Centre ID:	OSV-0005387
Date of Inspection:	12 April 2017 and 13 April 2017
Date of response:	28 June 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 01: Residents Rights, Dignity and Consultation
Theme: Individualised Supports and Care **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** It was not evident that residents were consulted about the choice of recently purchased

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

beds for the centre that were not necessarily required for residents based on their assessed needs.

1. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
. There will be a MDT assessment of each individuals needs and the type of bed they require. This will be done with full consultation with the resident. The process will be recorded in the residents' personal plan.

Proposed Timescale: 09/06/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The location of the central office in one unit was impacting on resident's privacy in the centre.

2. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
Access to the staff office will be directly into the office rather than through the residents' home. This will be facilitated with the replacement of a window with a front door.

Proposed Timescale: 30/06/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents were being charged different fees for the same services being provided in the centre.

Some language used in residents' records was not respectful.

3. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of

each resident.

Please state the actions you have taken or are planning to take:
1. Contracts of care will be reviewed for all residents to ensure that all residents re being charged the same
2. A documentation audit will be completed to ensure that the language in all residents records is respectful and professional.
3. Staff will be educated on the use of professional language in all documentation.

1.and 2. 16th June 2017
3. 30th June 2017

Proposed Timescale: 30/06/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some resident social care needs were not being met in the centre.

Goals set for some residents were not progressed so as to improve outcomes for them.

4. 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:
There is a detailed assessments in place carried out by the Occupational Therapist in consultation with the resident and Key Worker into the interests of each resident and is available in the resident's personal plan.
1. Training will take place for all staff on meaningful activities both within the home and in the community
2. The reorganisation of day services staff to facilitate more person centred activities which are both centre based and within the community.
3. Audits will take place to determine 1. the level of social care needs that are being met/not met and 2. goals that are set which are progressed / not progressed. The results of these audits will form an action plan to be implemented to ensure social care needs are being met and goals progressed for each individual within the centre.
4. Recruitment campaign to attract volunteers to support person centred activities both within the centre and community.
1. 28th July 2017
2. 15th September
3. 28th July 2017
4. 29th September 2017

Proposed Timescale: 29/09/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews completed by allied health care professionals were not always included in residents personal plans in order to guide practice.

The minutes of multi disciplinary review meetings viewed by inspectors did not demonstrate how this review was improving outcomes for residents.

5. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
1. A Standard Operating Procedure has been completed to outline to all staff involved in the documentation of care to include any recommendations from the allied healthcare professionals. This will be recirculated to staff and further reinforced with audit.
2. The multidisciplinary documentation will be reviewed to ensure suitability of the recording form and that the form demonstrates how the review is improving residents outcomes. There will be training for staff regarding the recording of minutes.

1. 16th June 2017
2. 31st July 2017

Proposed Timescale: 31/07/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The kitchen in one unit required repair due to a burnt counter-top and a dirty and damaged cooker hob.

6. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
1. The kitchen unit has been repaired.
2. The hob will be replaced

1. 9th June 2017
2. 30th June 2017

Proposed Timescale: 30/06/2017

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:
Residents individual risk assessments were not included in their personal plans in order to guide practice for staff.

One resident assessed as being a high risk of falls had no plan in place to outline the control measures in place to mitigate this risk and this risk was not highlighted on the centres risk register.

Control measures identified in response to an incident review were not always implemented into practice.

It was not clear how learning from the review of incidents in the centre was communicated back to staff to inform practice.

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

Please state the actions you have taken or are planning to take:
1. Relevant information from individual resident risk assessments will be included in residents personal plans to guide practice for staff
2. The resident with a high risk of falls will be reassessed and a plan will be put in place to outline control measures to mitigate this risk. This will also be placed on the centres risk register.
3. The Person in Charge and the Clinical Nurse Manager will ensure that control measures identified in response to an incident are implemented into practice through regular supervision of staff while on duty and informing staff at regular staff meetings.
4. A detailed document is completed on a regular basis identifying recent incidents per centre and further broken down by resident. This is discussed by the Risk Management Coordinator with the Person in Charge and Clinical Nurse Manager. This document is placed in a dedicated folder where staff are requested to read and sign the signature page confirming they have read same. This is also brought to the attention of staff at staff meetings and handovers.

1. and 2. 23rd June 2017
3. and 4. 30th June 2017

Proposed Timescale: 30/06/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident's personal emergency evacuation procedure did not include all the supports required for this resident in the event of an evacuation of the centre.

There were no records to demonstrate how issues identified at one fire drill had been responded to review and inform future fire drills.

8. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
1. The resident's personal emergency evacuation procedure will be reviewed and will include all supports required for the resident in the event of an evacuation of the centre.
2. The Risk Management Coordinator will review and document the issue that occurred at the recent fire drill within this centre and the outcome from this review will inform policy and future fire drills.

Proposed Timescale: 30/06/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Four staff were not trained in challenging behaviour and a restraint intervention.

9. 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:
1. All staff will be trained in the Prevention and Management of aggression and Violence (PMAV)
2. All staff in the centre will be trained in restraint and the interventions techniques in use in the centre.

Proposed Timescale: 04/08/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some information contained in behaviour support plans was not reflective of the actual practice in the centre and did not guide practice.

10. 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:
1. All residents support plans for behaviours of concern will be reviewed to ensure they reflect and guide practice in the centre
2. All new staff will be trained in the prevention and management of aggression and violence and inducted locally on all residents support plans for behaviours of concern
1. 30th June 2017
2. 4th August 2017

Proposed Timescale: 04/08/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of restrictive practices in the centre did not demonstrate what alternatives had been considered if any so as to ensure that the least restrictive practice was being used.

11. 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 restrictive practices in the centre will be reviewed by the PIC and Multi Disciplinary Team. Alternatives will be explored to ensure that the least restrictive practices are being used.

Proposed Timescale: 21/07/2017

Theme: Safe Services

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

Recommendations from a review of safeguarding incidents were not always implemented.

12. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
A review will take place by the Person in Charge and Clinical Nurse Manager to ensure all recommendations made by the Safeguarding Committee for this centre are in place.

Proposed Timescale: 16/06/2017

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:
Signature banks had not been completed by all staff administering medications.

Not all medications were signed for by the administering staff member.

Some prescribed medications did not have the prescriber's registration number listed as required by the designated centre's policy and procedures for medication management.

The findings from a medication audit completed found that some administration errors occurring in the centre had not been recorded as a medication error.

13. 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:
1. All nursing staff administering medication will have their signatures at the back of the medication kardex in the signature bank
2. Where over the counter medication is administered by non nursing staff this will be outlined in the residents care plan and highlighted in the medication kardex using the relevant code in the timeslot.
3. The GP will be notified of the identified issue following the recent inspection
4. All medication errors found at time of audit will be recorded as medication errors in the centre.
1. 23rd June 2017
2. 7th July 2017
3. 09th June 2017
4. 16th June 2017

Proposed Timescale: 07/07/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Self administration of medication assessments were not completed.

14. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
Self Administration of medication assessments will be complete for all residents.

Proposed Timescale: 07/07/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Protocols for the administration of p.r.n. medication were not implemented.

Staff were unsure about when to seek assistance from authorised staff for the administration of some p.r.n.medications.

15. 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:
PRN protocols will be implemented.
Staff will be trained on the use of PRN protocols and when to seek assistance from authorised staff for the administration of PRN medication.

Proposed Timescale: 30/06/2017

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 measures in place to monitor the quality of care in the centre were not effective as a number of actions had not been fully implemented and there was a lack of oversight for the completion of these actions so as to improve the quality of services in the centre.

16. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
1. Action plans in place will be reviewed by the Person in Charge and Clinical Nurse Manager on a weekly basis to insure all actions have been completed.
Corporately;
2. Quality Walk Arounds are taking place on a regular basis within the service
3. There is a HIQA Oversight Committee in place chaired by a Board member with another in attendance and the management team for the intellectual disability service with oversight for HIQA action plans and their implementation.
4. Regular meetings are taking place between the Director of Nursing and the Clinical Nurse Manager of the centre.
5. Roll out of leadership training for all Persons in Charge in the Intellectual Disability Service has commenced.
1. 16th June 2017
2. 9th June 2017 and ongoing
3. 18th July 2017
4. 16th June 2017 and ongoing
5. 29th September 2017

Proposed Timescale: 29/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff meetings were not held on a regular basis in the centre.

17. Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
Staff meetings will take place quarterly in each individual house with their dedicated staff. Minutes will be taken and all staff not present at the meeting will be asked to read and sign on signature page.

Proposed Timescale: 30th June and ongoing

Proposed Timescale: 30/06/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review for the centre did not include consultation with residents or their representatives.

18. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
Future annual reviews will include consultation with residents and relatives. With residents this will take place through residents meetings and Speak Up Group. Families/representatives will be consulted during the residents annual review and through yearly family questionnaires

Proposed Timescale: 15/12/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Significant numbers of agency staff employed in the centre.

19. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
1. Regular recruitment drives for relief and permanent staff
2. Recent recruitment for 17 staff for the recruitment panel
3. Agency usage to continue to decline and to remove all agency by Quarter 4 2017.

1.and 2. 31st May 2017
3. 31st December 2017.

Proposed Timescale: 31/12/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate staff numbers were not present to support residents needs during specified times in one unit of the centre.

20. 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 roster will be reviewed to ensure that there are appropriate staff numbers available to support residents in the morning to facilitate getting up and breakfast.
The CNM will ensure that this roster change is implemented and supervised.

Proposed Timescale: 16/06/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two polices had not been reviewed in line with the timeframes specified in the regulations. These included:

- The policy on restrictive practice.
- The policy on nutritional intake.

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

Please state the actions you have taken or are planning to take:
1. The policy on restrictive practice being reviewed and updated.
2. The policy on nutritional intake will be reviewed and updated

Proposed Timescale: 16/06/2017