

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | Edencrest & Riverside |
| Centre ID: | OSV-0005487 |
| Centre county: | Donegal |
| Type of centre: | The Health Service Executive |
| Registered provider: | Health Service Executive |
| Provider Nominee: | Jacinta Lyons |
| Lead inspector: | Anne Marie Byrne |
| Support inspector(s): | None |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 11 |
| 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 28 March 2017 09:00 To: 28 March 2017 17:30

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

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| 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 inspector met with ten residents, five staff members and the clinical nurse manager during the inspection process. Not all residents were able to communicate with the inspector. The centre is situated on a campus setting and consists of two houses, and both houses were visited by the inspector.

The inspector reviewed practices and documentation, including four residents' files, three staff files, incident reports, action plans, 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 outskirts of Stranorlar, Co. Donegal. 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. Of the two houses in this centre, one provides accommodation for five residents ranging in ages from 31 to 70 years. The other house provides accommodation for residents ranging in age from 27 to 63 years of age. Both houses are bungalow dwellings and have a communal kitchen, dining room, sitting room, enclosed garden area and bedroom spaces for residents. No residents were scheduled to transition into the community at the time of inspection.

There was no person in charge appointed with responsibility for the centre at the time of inspection. The management of the centre was overseen by the clinical nurse manager and the provider until a person in charge was appointed. The clinical nurse manager works directly on the campus setting and regularly visits each centre to meet with staff and residents.

Overall judgment of our findings:

This was Edencrest and Riverside's first inspection as a designated centre. The centre was previously inspected as part of Ard Greine Court Services. Five outcomes were inspected as part of this inspection process, with four out of five outcomes found to be in major non-compliance. The inspector found one outcome to be in moderate non-compliance. These outcomes relate to social care needs, health, safety and risk management, safeguarding and safety management, governance and management and workforce.

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):

This was the centre's first inspection by the Authority.

Findings:

In the main, the inspector found residents had opportunities to engage in social activities. Residents' social care needs were assessed and residents were involved in their personal planning and personal goal development. However, upon this inspection, the inspector found staffing arrangements were not consistent in meeting the assessed social care needs of residents. Furthermore, improvements were required in the recording and updating of personal goals.

Residents were involved in the development of their personal plans and personal goals. Where residents were unable to communicate their wishes, they were supported by staff and their families in developing these plans and goals. Meetings were held on a regular basis with residents to review the progress made towards their personal goal achievement. However, the inspector found that action plans were not always developed following these reviews which identified those responsible for supporting the resident to achieve these goals within measurable timeframes. Gaps were also found in the updating of action plans to demonstrate the progression made by residents towards achieving their identified goals.

Some residents in the centre presented with severe intellectual disability and were assessed as requiring one-to-one and two-to-one staff support for social activities. Other residents were assessed as requiring minimal staff support for social activities. Individual activity schedules were in place for all residents, which outlined the planned activities on a Monday-Friday basis. At weekends, staff met with residents to identify and plan with them how they wished to spend their weekend. However, staff informed the inspector that adequate staffing levels were not always in place, which impacted on the quality of

social care provided to residents. On days where additional staff supports were provided to the centre, staff informed the inspector that they were able to bring residents on group outings, plan individual trips while also allowing for residents to remain in the centre, if they chose not to participate in a social outing. However, on days where this additional staff support is not provided, staff informed the inspector that residents do not receive the same social care opportunities, resulting in planned activities not going ahead due to staffing resources.

The clinical nurse manager informed the inspector that a business case had been submitted for additional social care support for the centre. The outcome of this business case had not been determined 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):

This was the centre's first inspection by the Authority.

Findings:

The inspector was informed by staff and the clinical nurse manager that improvements had been made to the centre's overall risk and fire safety management systems. However, upon this inspection, clarity was required in relation to the assessment of some risks identified within the centre.

At the time of inspection, all staff were found to have up-to-date fire safety training. Evacuation plans were in place for each resident which guided staff on the individual supports required by residents in the event of a fire. Fire responders were identified daily in each house within the centre to assist in evacuation should a fire occur on the campus setting. Fire drills were occurring on a six-monthly basis and records of these drills reviewed demonstrated residents were successfully evacuated from the centre. Staff spoken with informed the inspector how they would respond in the event of a fire, and of their responsibility for the evacuation of residents in such cases. However, where security gates were in place within the enclosed garden, keys to unlock some gates were not readily accessible to allow residents or staff access to the fire assembly point.

Management and staff demonstrated to the inspector a good understanding of the centre's risk management processes. Resident and organisational specific risks were assessed and control measures put in place to mitigate these identified risks. A risk

register was maintained for the centre which demonstrated a reduction in initial risk ratings through the implementation of effective risk management activities. However, some gaps in the assessment of risk were identified by the inspector during the inspection. For instance, although the centre had risk assessments in place for resident who wished to smoke, these risk assessments were clinically orientated and did not consider the safety of residents while smoking. In addition, risk assessments to support the application of some restrictive practices were not completed. Furthermore, where residents were identified at risk of absconsion, staff were unclear what the exact control measures to be implemented were to mitigate this risk. This was brought to the attention of the clinical nurse manager during the course of the inspection.

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):

This was the centre's first inspection by the Authority.

Findings:

The provider had made some recent improvements to the monitoring of safeguarding concerns and the management of behaviour that challenges within the centre. Upon this inspection, the inspector found improvements were required in relation to providing staff with up-to-date knowledge and guidance on how to respond to residents' specific behaviour that challenges.

A record of safeguarding concerns within the centre was maintained. This record provided an overview of the nature of safeguarding concerns that were identified, and the current management status of these safeguarding concerns. The clinical nurse manager informed the inspector that this record was used to inform the on-going review of safeguarding plans within the centre. The inspector found safeguarding plans provided guidance to staff on how they were required to safeguard residents on a daily basis. All staff had up-to-date safeguarding training at the time of inspection. Staff spoken with were knowledgeable of the requirement to report safeguarding concerns.

Restrictive practices were in use in the centre, at the time of inspection. Where residents were prescribed a chemical restraint, risk assessments and protocols were in place to

guide staff on its appropriate application. Staff were knowledgeable on all de-escalation techniques to be implemented, prior to resorting to giving a chemical restraint. On the day of inspection, some kitchen doors within the centre were found to be locked. Staff informed the inspector that this was to ensure the safety of some residents who required supervision when accessing the kitchen. However, this restrictive practice was not supported by a risk assessment and documented guidance was not available to staff on the appropriate application of this restriction.

There were residents with behaviour that challenges residing in the centre. Staff were supported by a behavioural management team in the management of these behaviours. All staff had received up-to-date training in the management of behaviour that challenges. On the day of inspection, the clinical nurse manager informed the inspector that some residents were experiencing changes to their behaviour management interventions, due to an increase in peer-on-peer incidents, occurring in the centre in recent weeks. A record of these incidents was maintained and the clinical nurse manager informed the inspector that this record had informed the review of behaviour support plans. However, the inspector found these behaviour support plans had not been updated to reflect the revised behavioural support interventions for these residents. In addition, agency staff were frequently allocated to houses where residents experiencing these behavioural changes resided. On the day of inspection, two out of the three staff rostered to this house were agency staff members. The inspector spoke with one of these agency staff members who informed the inspector that it was their second time to work in this house, and that they were not very familiar with the residents or with how to support their changing behavioural support needs.

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):

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

Findings:

The inspector found that significant improvements were required with regards to the centre's overall governance and management systems.

At the time of inspection, there was no person in charge appointed with overall management responsibility for the centre. The clinical nurse manager and the provider were overseeing the governance and management arrangements of the centre until a person in charge was appointed. The clinical nurse manager worked on the campus setting and had opportunities to visit and meet with staff and residents daily. The clinical nurse manager had a good knowledge of the residents and their needs. Arrangements were put in place to support, develop and performance manage members of staff to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. This process was being monitored and implemented by the clinical nurse manager, and was on-going at the time of inspection.

There was evidence that some governance and management systems were in place. However, the oversight of these governance and management systems was ineffective. For example, the inspector completed a review of the centre's action plans in relation to six monthly unannounced visits, the annual review of the service and the centre's quality improvement plan. Each action plan demonstrated gaps in the centre's overall deadline achievement, with no evidence of review of when overdue actions would be brought back within achievable timeframes. Furthermore, the inspector found repetition in the actions overdue in relation to additional staffing levels required by the centre. Management staff spoken with informed the inspector, that there was no formal review process in place which regularly informed and updated them on the progression made to secure these additional staff hours.

In addition, at the time of inspection a team were identified to conduct a number of residents' capability assessments to assess residents suitability to live together. However, the clinical nurse manager informed the inspector that although the centre had experienced 11 peer-on-peer incidents since July 2016, there was no process in place to indicate to management staff when these compatibility assessments would be completed or the priority in which assessments would be conducted.

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):

This was the centre's first inspection by the Authority.

Findings:

Prior to this inspection, the centre had completed a number of training days with staff to ensure all staff had received up-to-date mandatory training. However, further improvements were required in relation to some staff training, staffing arrangements and the maintenance of schedule 2 documents.

A training matrix for staff working in the centre was in place and this demonstrated staff had received up-to-date training in fire safety, safeguarding and in the management of behaviours that challenge. However, not all staff had received up-to-date training in manual handling.

A sample of staff files were reviewed by the inspector and gaps were identified in the maintenance of documentation to include; satisfactory history of gaps in employment, dates of commenced employment and references.

Planned and actual staff rosters were available in each house of the centre which demonstrated high levels of agency staff were being rostered within the centre. For instance, in February 2017, the centre used agency staff on 21 days in the 28 day rostering period. For six of these days, the same agency staff member was allocated to the centre. On all other days, residents were cared for by a different agency staff member. The inspector spoke with permanent staff members of the centre who informed this inconsistency in care delivery impacted on residents' behaviours, some of whom did not like to be cared for by unfamiliar staff. Upon a further review of the roster, the inspector found occasions where the rostering arrangement consisted of one permanent staff member, with the remaining staff compliment consisting of agency staff. Although an induction process was in place for agency staff, it was orientated around the health and safety of the premises and did not provide adequate guidance on the care delivery, specific to the residents to be caring for. During the inspection, the inspector spoke with an agency staff member who said that it was their second time to work in the centre, and they were not familiar with the residents' specific care needs.

The inspector found there were inadequate staffing levels to meet the social care and behavioural support needs of residents. Where residents were assessed as requiring one-to-one or two-to-one staff supports, the staffing levels were not always in place to meet these assessed needs. The inspector met with staff and were told that where adequate staffing levels were not provided each day, staff did not have sufficient capacity to meet the needs of residents in the centre. In addition, following a recent review of the centre's arrangements to support residents' behaviours, the centre were advised by external personnel that the current staffing arrangements in this centre were not adequate to support the behavioural support needs of residents. In response to this, staff were allocated for one-to-one resident care where residents presented with increased episodes of behaviours that challenge. However, this staffing resource was provided through the re-allocation of staff duties, and not in addition to the existing staffing compliment. The inspector was informed by staff that this arrangement placed further strain on the remaining staff members to continue to try and meet the needs of other residents residing in 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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

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| Centre name: | A designated centre for people with disabilities operated by Health Service Executive |
| Centre ID: | OSV-0005487 |
| Date of Inspection: | 28 March 2017 |
| Date of response: | 29 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, following personal plan reviews, that a clear record was maintained of the names of those responsible for pursuing objectives in the plan within agreed timescales.

1. Action Required:

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

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

The Acting Clinical Nurse Manager 2 and the Acting Director of Nursing will ensure that recommendations arising out of each personal plan review are recorded and includes proposed changes to the personal plan, the rationale for proposed changes, the names of those responsible for pursuing the objectives in the plan and the agreed timescales for completion.

Audits were completed on 8 Personal plans, with Named Nurse & Key Worker highlighted on each plan as responsible for pursuing objectives within agreed timeframes.

The remaining 3 Personal Plans are currently being updated and will have a named nurse and key worker highlighted on each plan as responsible for pursuing objectives within agreed timeframes.

Proposed Timescale: 30/05/2017

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 personal plans were updated to reflect the progress made towards residents' personal goal achievement.

2. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

The Acting Clinical Nurse Manager 2 and the Acting Director of Nursing will ensure that the updated annual review template is used by all staff in the centre going forward; this template will capture the assessment of the effectiveness of each plan and changes in circumstances and new developments.

The Acting Clinical Nurse Manager 2 and the Acting Director of Nursing will ensure that personal plans are updated on a quarterly basis or more frequently if required to reflect the progress made towards personal goal achievement.

8 Personal Plans have the progress / evaluation notes included with regular evaluations taking place.

Work is continuing on the remaining 3 Personal Plans.

Staff has been given direction and assistance in order to develop same.

Proposed Timescale: 30/05/2017

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 arrangements to:

- Ensure staffing arrangements were consistently in place to meet the assessed social care needs of residents.
- Ensure assessment and planning was in place to identify and meet the assessed needs of residents with severe intellectual disability

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 Acting Clinical Nurse Manager 2 and the Acting Director of Nursing has met with the residents, named nurses and key workers to discuss and establish effective time tables which are meaningful for each individual – completed.

Assessments will be completed to identify the staff support requirements each individual has in order to partake in various activities.

The risk assessment regarding staffing levels has been completed and escalated within the Service. Workforce Planning is in process in the Service to address the additional support needs of each resident.

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:

The provider failed to ensure risk management processes were in place for:

- the implementation of control measures for residents identified at risk of absconion.
- appropriate assessment of residents who wished to smoke
- appropriate assessment for the use of restrictive practices

4. 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. Updated preliminary screening and Risk Assessments with updated control measures have been completed for the resident at risk of absconding and all staff in the centre have been made aware of the updated control measures to mitigate the risk.

2. Updated preliminary screening and Risk Assessments with updated control measures have been completed for the resident who smokes and all staff in the centre have been made aware of the updated control measures to mitigate the risk.
3. Assessments for the use of all restrictive practices in place in the Centre have been reviewed. Restrictive Practices are now clearly outlined within the Health and Safety Statement.
4. An Induction Process has been introduced for all new staff working in the centre. This includes profiles of each resident, individual risk assessments and control measures to mitigate risks, restrictive practices in use in the centre, safeguarding plans and Positive behaviour support plans.

Proposed Timescale: 4 May 2017 completed

Proposed Timescale: 04/05/2017

Theme: Effective Services

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

The provider failed to ensure keys to open perimeter gates located outside fire exit doors were accessible in the event of an evacuation.

5. Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

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

The Acting Clinical Nurse Manager 2 and the Acting Director of Nursing will ensure that a key pad system is installed on each perimeter gate to ensure safe means of escape in the event of an evacuation.

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:

The provider failed to ensure staff had up-to-date documented guidance to respond to behaviour that is challenging and to support residents to manage their behaviour.

6. 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. An Induction Process has been introduced for all new staff working in the centre. This includes profiles of each resident, individual risk assessments and control measures to mitigate risks, restrictive practices in use in the centre, safeguarding plans and Positive behaviour support plans.
2. All Behavioural Support Plans have been reviewed by the Clinical Psychologist. These have been brought to the attention of all staff within the Centre.
3. Agency Staff will be provided with training on the management of behaviours of Concern and Safeguarding.

Proposed Timescale: 31/07/2017

Theme: Safe Services

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

The provider failed to ensure that where physical restrictive procedures were in place, they are applied in accordance with national policy and evidence based practice.

7. 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 Acting Clinical Nurse Manager 2 and the Acting Director of Nursing will complete a Risk Assessment regarding the current practice of locking the kitchenette door to ascertain if there are less restrictive approaches that could be used.

A protocol to inform staff will be documented following risk management.

The Acting Clinical Nurse Manager 2 and the Acting Director of Nursing will ensure all Positive Behaviour support plans are updated to ensure staff working in the centre are kept well informed.

Proposed Timescale: 20/06/2017

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 provider failed to appoint a person in charge to the centre.

8. Action Required:

Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

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

The Provider has identified a person in charge for the centre. The person identified is undertaking a Management and Leadership programme which will be completed by 30th September 2017. An Acting CNM2 has also been appointed to the centre. The A/CNM2 receives regular supervision by the A/Director of Nursing.

Proposed Timescale: 30/09/2017

Theme: Leadership, Governance and Management

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

The provider failed to ensure the governance and management systems in place were effective:

- in monitoring and achieving the delivery of scheduled works within agreed timeframes
- provided members of management with regular updates on the progression of required actions for the centre

9. 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. The Acting Clinical Nurse Manager and the Acting Director of Nursing will ensure that all outstanding actions from the 6 monthly unannounced visit, the annual review and the Quality Improvement Plan will be completed.
2. Workforce Planning has commenced in the centre to ensure appropriate staffing is in place to respond to the needs of residents living in the centre.
3. Compatibility assessments have been completed.
4. Option appraisals will be developed with residents and their representative s to identify alternative accommodation where necessary.
5. Transition planning will commence when alternative accommodation is sourced.

Proposed Timescale: (1) 30 June 2017 (2) July 31st 2017 (3) Completed (4) August 30th 2017 (5) December 31st 2017

Proposed Timescale: 31/12/2017

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 was appropriate to the number

and assessed needs of the residents.

10. 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:

Workforce Planning has commenced in the centre to ensure there is an assessment of supports completed and to ensure appropriate staffing to respond to the needs of residents living in the centre.

In the immediate time frame agency staff are being employed to ensure adequate staff are present to support the residents.

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 all information and documents as specified in schedule 2 of the regulations was maintained for all staff.

11. 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:

- An Audit of Schedule 2 documentation in Staff Personnel Files has been completed.
- Awaiting Garda Vetting for 6 staff members.

Proposed Timescale: 31/08/2017

Theme: Responsive Workforce

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

The provider failed to ensure residents receive continuity of care and support, particularly in circumstances where agency staff are employed.

12. 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:

Workforce Planning has commenced in the centre to ensure there is an assessment of

supports completed and to ensure appropriate staffing to respond to the needs of residents living in the centre.

The acting CNM2 and Acting Director of Nursing will make every attempt to have familiar agency staff on duty where possible within the designated centre.

All agency staff receives induction as per HSE policy.

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 all staff had up-to-date manual handling training at the time of inspection

13. 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:

1 staff did not have up to date Manual Handling training at the time of the inspection, This staff has now completed same.

Proposed Timescale: Completed

Proposed Timescale: 29/05/2017