<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Adults Services Palmerstown Designated Centre 5</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003902</td>
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<tr>
<td>Centre county:</td>
<td>Dublin 20</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Stewarts Care Limited</td>
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<tr>
<td>Lead inspector:</td>
<td>Louise Renwick</td>
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<tr>
<td>Support inspector(s):</td>
<td>Amy McGrath; Thomas Hogan</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>27</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>5</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
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 renewal decision. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

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<tr>
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<th>To</th>
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<tr>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

Background to the inspection:

This was an unannounced inspection to assess the designated centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was the Health Information and Quality Authority's (HIQA) fifth inspection of this designated centre which was completed over two days. The centre was last inspected on October 2017 where inspectors found the nine outcomes inspected against to be in major non-compliance with the Regulations.

The provider had been issued a Notice of Proposal to cancel and refuse the Registration renewal of the centre in August 2017, to which the provider had submitted representation in September 2017. Subsequent to this the provider was subject to a six month escalation plan and was required to provide monthly assurances to HIQA. The purpose of this inspection was to monitor for improvement with the Regulations and improvements in the lived experience of residents across
the four units of the Designated Centre, now that the assurance reporting process was drawing to a close.

Description of the service:
The service provider had produced a statement of purpose which outlined the service provided within this designated centre. The centre was located in a large campus based setting in Dublin and was comprised of four detached buildings which, at the time of inspection provided residential services to 27 persons with disabilities.

How we gathered our evidence:
The inspector met 17 of the 27 residents living in the centre during the course of the two days of inspection, and observed residents in their home and some interactions between staff and residents. The inspector also spoke with a number of different staff members across the four units, the person in charge, the transitions manager, a clinical nurse specialist and the director of care. Various sources of documentation were reviewed including residents' files, policies and procedures, risk assessments, health monitoring records, complaints logs and management meetings and audits.

Overall judgment of our findings:
Overall, inspectors found while there was an emergence of improvement across the outcomes inspected, these improvements were not consistent in all units of the designated centre. Learning from successful implementation of new ways of delivering care in some units, had not been replicated in others which resulted in varying experiences for residents living in the designated centre. While inspectors noted the actions the provider and senior management team were carrying out as part of the assurance process, it had not consistently improved the lived experience of residents across all units. Inspectors found in some units of the centre, there was a resource led focus in place of individual person centred care and support.

Areas in need of significant improvement were in relation to risk management. There was an absence of a robust system and understanding of effective risk management that both protected and empowered residents. There was ineffective oversight to ensure where risks had been identified and that control measures were understood and implemented for the benefit of residents. Linked to this, the system for reviewing and responding to incidents and adverse events was not ensuring patterns and trends were clearly and swiftly identified so as to alert a change in interventions and supports for residents in a preventative and proactive way. While improvements were noted in the quality of information within care planning documentation for healthcare needs, there remained a lack of effective monitoring systems for the provider to assure themselves that residents were in receipt of adequate food and fluid in line with their individual needs. There also remained gaps in the planning for particular health issues for residents.

Improvements were required by the provider to ensure fire safety practices were overseen and protecting all residents from the risk of fire. Following feedback, the provider arranged for any fire exits that were obstructed to be accessible, and for a relevant person to complete a walk-around of the units and address any issues raised through the inspection process.
In response to the verbal feedback given to the provider and management team following the inspection, inspectors received an email informing them that a number of key issues had been responded to in relation to the review of particular risks, and the commencement of investigations into two incidents mentioned within the report. The provider also undertook a safeguarding screening in relation to the provision of food available in the evening times for residents, which found no grounds of concern on the basis of neglectful practice in this regard.

These findings, along with further details, can be found in the body of the report and accompanying action plan.
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspectors found that there had been improvements in how residents' privacy and dignity was upheld and respected in the designated centre, however there were further improvements required.

At the time of the last inspection, there were a number of residents sharing a bedroom. Since that inspection each resident now has their own bedroom. Each resident could also access a bathroom without entering another resident's bedroom. Privacy arrangements had been improved for bathrooms, to promote and maintain the dignity of residents, and all toilets had a door in place at the time of inspection.

Efforts had been made to review the use of antiandrogen medication for two residents. One resident had been reviewed by a psychiatrist, and had the dosage of this medication reduced, with a view to discontinuing the medication entirely. Another resident had been scheduled for a review with psychiatry to have this medication discontinued. The local manager had also contacted an external advocacy service to support these residents with this matter. Other restrictive practices in place for these residents had been reviewed, with some being reduced, and others removed entirely.

The centre had a complaints policy in place, and there was a nominated person to deal with complaints on behalf of residents. The centre maintained a record of complaints made, and most were responded to promptly. There were some improvements required to ensure consistency in the management of complaints, as some complaints had not been responded to on the day of the inspection, despite having a direct impact on
residents. Another complaint escalated to the organisations complaints committee had not been responded to after a period of five months.

There were significant improvements required to ensure that residents had opportunities to participate in, and consent to decisions about their care and support, and to exercise choice and control in their daily lives. For example, meals were prepared in a central kitchen, and reheated in the centre. While staff spoken with told inspectors that residents could participate in choosing a menu on a weekly basis, this was not reflected in practice. Residents had limited ability to verbalise their preferences, and the same prepared meal was observed in numerous units of the centre. In some houses, staff spoken with told inspectors that there was no food prepared on the premises, and no meals served after 17:00 hours. This practice did not support residents to exercise choice in their daily lives. As mentioned previously, following on from the inspection the provider carried out a safeguarding screening in relation to the provision of food in the evening times, which found no grounds for concern.

The systems in place to support residents to manage their finances were not person centred, and institutional systems resulted in residents having limited access to their own personal finances. For example, residents, with the assistance of staff plan out their week's activities and submit a request to the organisations accounts department, with one weeks notice, to access their own money.

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

Findings:
Overall, the inspectors found that while there were significant improvements made, there remained some actions outstanding to ensure that the design and layout of the designated centre was meeting the residents' individual and collective needs in a comfortable and homely way.

There had been progress on actions from the previous inspections, however not all of the actions were satisfactorily implemented from the last inspection report, and the
provider's own audits. At the time of inspection, each resident had their own bedroom. Inspectors spoke with staff and reviewed actions from a previous unannounced visit on behalf of the provider in May 2018 which highlighted the need for more space in a resident's bedroom in order to assist with manual handling and care of the resident while in bed. Inspectors saw this resident's room and found that due to the size of the room and position of the bed, space was limited in order to support the resident while lying down.

There were sufficiently sized communal areas available, and large outdoor dining facilities available in each unit of the centre. The provider had also improved access to toilet and shower facilities; in one unit the layout of a bathroom was changed to promote privacy and dignity, and residents could each access bathroom facilities without entering another resident's bedroom. Most bathrooms contained improved hand-washing facilities, although in one unit in a large bathroom, there was no soap or soap dispensers available.

There were some outstanding works required in relation to maintenance and general upkeep of the centre. There were numerous areas that required repainting and one unit had significant damage to the plaster in the laundry room, to which emergency keys were affixed. Some bathrooms contained damaged floor tiles, and inspectors observed a number of broken blinds throughout the centre.

The centre had assistive devices for residents, where required, for example, hoists, and these were serviced by an external company, within an appropriate timeframe. There were improvements required to ensure that assistive equipment, and facilities for residents were repaired in a timely manner to ensure minimal disruption to residents. For example, a shower chair used for one resident was reported as broken, and had been unavailable for the resident to use. This remained outstanding on the date of inspection, despite being alerted to the technical services department more than three weeks previously. Furthermore, a request to adapt the layout of the kitchen to an open plan style in order to provide access to residents had not been followed up at the time of inspection.

Judgment:
Non Compliant - Moderate

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:
Inspectors found that residents were not protected through effective risk management systems and learning from incidents and adverse events in the designated centre. Due to the concerns found on the day of inspection, the provider was required to provide immediate assurances in relation to health, safety and risk management. The provider subsequently provided assurances stating that measures would be implemented to mitigate the risks identified by the inspectors.

Inspectors reviewed the risk management policies and spoke with management and staff and reviewed a number of risk assessments. Inspectors found that policies were out of date and in need of review. While the policy content was good it was not followed in practice in the organisation. The provider was aware of these deficits and was in the process of recruiting a new role in the organisation to oversee the management of risk. Inspectors found that for a number of risks in the centre, written risk assessment had been completed which highlighted control measures that alleviated the risk. A sample of these risk assessments were seen by inspectors and had been reviewed in June 2018. That being said, not all hazards in the centre had been identified, and the review of adverse events was not used as an opportunity to identify emerging hazards and risks for the benefit of residents' safety. There were gaps in the system in place to effectively identify risks and put plans in place to reduce them. In the absence of effective systems and oversight there was potential for the safety of residents, staff and visitors to be compromised, which was evident through the incident records.

Improvements were also required in relation to the management of known risks. Inspectors spoke with staff, observed residents and walked around the designated centre and found that for some identified risks, control measures were not in place to protect residents from harm. For example, chemicals and toiletries were accessible in the main bathroom of a unit, when a risk assessment indicated these must be locked away to prevent ingestion. The staff present during the inspection immediately addressed this and removed items back to a lockable press. On review of incidents, inspectors found that while control measures had been agreed and documented, in the previous months a resident had successfully obtained items that could have caused harm.

Inspectors found that some control measures in response to known risks were not balanced, and the negative impact on residents' quality of life had not been considered. While it was a positive finding that the provider had put one to one staffing in place in response to a risk, staff felt that the resident did not enjoy being supervised and monitored by one staff member so closely. The purpose of this increased supervision was to protect the resident, and their peers. However, a review had not been completed to fully understand the reason for the behaviour that was problematic, and to look at the environment and other factors as a barrier to improvements. While it was a positive short term measure in response to a concern, a wider solution encompassing of the resident's quality of life had not been considered. Overall, risk management practices were in need of significant improvement to ensure residents were both protected from risk along with ensuring they were not negatively impacted from control measures.

Practices in some units of the centre were not in line with the promotion of residents' safety. For example, in one part of the designated centre a number of residents were identified as being a risk of falls. On the day of inspection, the floor of the communal
living space was being mopped. Inspectors were informed that this was the only time this could occur due to the hours worked by household staff. Some residents were walking through the living space during cleaning. This was not considered as a risk, or as a practice that was not in the best interests of residents and visitors.

While there was a system for recording accidents, incidents and adverse events, improvements were still required regarding the review of adverse events and learning gained, and the pathway of escalation. Inspectors reviewed incident, accident and adverse event records that were made available in the designated centre, and found that improvements were required. For example, while a risk committee met regularly to review incidents, the process around recording, inputting information and gaining data from trends took significant time. Minutes of these meetings did not clearly show what was discussed and what learning was gained. For example, there had been an incident for a resident which resulted in hospitalisation. There had been a pattern of falls and adverse events prior to this incident. The local manager had requested a review of physiotherapy needs following an earlier fall, and this had been carried out. However, it was not clear on the incident record if this advice had been followed in practice.

Similarly, there had been a serious incident with staff and residents while out on a community outing. This had not been reviewed effectively to identify contributing factors to the incident from a comprehensive, no blame point of view. For example, just prior to the outing resources that should have been available fell through, resulting in staff having to rearrange the plan last minute with agency staffing in an effort for the outing to still go ahead.

Overall, inspectors were not assured that the system to identify and manage all risks was robust, and fully promoting the safety of residents, staff and visitors.

While there had been progress on some actions from the previous inspection in relation to fire safety, there remained significant concerns in relation to fire safety management within the centre. There was one fire drill on record for each unit of the designated centre for the year to date. Each resident had an individual emergency evacuation plan, which detailed their needs and level of support required to safely evacuate the premises. However, not all of these had been updated to reflect learning from fire drills. For example, one person who used a wheelchair was required to evacuate from the first floor via a stair well. Staff spoken with said that this person could use the stairs, and would safely evacuate in the case of a fire. However, evacuation records noted that the person had difficulty with stairs and did not fully evacuate during a recent fire drill. This was not reflected in the resident’s personal evacuation plan. There were also improvements required in evacuation planning for the centre as a whole, considering the level of support required by residents to evacuate, numbers of staff available, and requirements to supervise residents once evacuated.

All fire fighting equipment reviewed on the day of inspection had been serviced in an appropriate time frame, and there was sufficient emergency lighting present in the centre. Each unit within the centre had fire containment measures in place. However, in one unit most of the self closing mechanisms on internal doors were not effective, and doors did not close fully; this included all residents' bedroom doors, and living room doors. This was rectified on the day of inspection. It was also found throughout the
centre that multiple fire doors were wedged open, and one fire door was held open by the cord of a nearby blind. There were serious concerns in relation to the accessibility of means of escape within the centre. In one unit, an internal fire door was blocked by laundry baskets, and external exits were blocked by storage containers. There were locks on internal doors that led to emergency exits, without emergency keys in place.

On review of training records provided, inspectors found that only 87% of staff employed to work in the centre had completed fire safety training, and 39 of the 45 staff had completed a fire drill.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

Findings:
Inspectors noted improvements in the quantity of incidents being viewed as safeguarding issues, and reporting them in line with national policy. Each of the three local managers were identified as designated officers, and were responsible for the screening of allegations or possible safeguarding concerns. While there were improvements in the recording and reporting mechanisms, this was not fully consistent across all units of the designated centre. On review of incident, accident and adverse events along with the safeguarding logs, not all safeguarding incidents had been reported in line with national policy and while improvements were noted, practice was still inconsistent.

Inspectors found that for the most part, local managers and staff teams were implementing safeguarding plans to prevent negative outcomes for residents and to protect them from harm. For example, there had been an increase in staffing levels, changes to residents' bedrooms and increased monitoring. That being said, safeguarding plans were not always successful at preventing incidents between peers from occurring. While safeguarding plans were aiming to address the immediate concerns, they were responsive and reactionary to patterns of peer to peer allegations and were reliant on
high levels of staff monitoring. The provider had not yet put proactive and long term solutions in place to ensure all residents were living in a suitable environment with a number and mix of peers that promoted a safe and comfortable living environment. Subsequent to the provider, in line with National Policy, reporting these incidents to the National Safeguarding Office, inspectors were informed that should another peer to peer allegation occur for some residents, it would be considered institutional abuse.

The amount of staff trained in safeguarding awareness had improved since the previous inspection, with records showing that 96% of staff employed by Stewarts Care to work in this centre had attended training. In speaking with permanent staff, inspectors confirmed that they had attended this training, and they could demonstrate knowledge on the different types of abuse, their indicators and who to report to.

There were a number of residents living in the centre who had additional supports needs regarding their behaviour. On review of documentation, inspectors found that there were policies in place for the provision of behaviour support, and the use of restrictive interventions. The policy in relation to behaviour support was in need of review and updating. Inspectors were informed that policies would be updated to reflect a framework of holistic support for residents who present with behaviour that can be challenging for the service. Post inspection, inspectors were sent a copy of the draft policy on positive behaviour support which had a focus on training staff teams in how to support individuals with behaviours of concern, and the monitoring of support plans to ensure effectiveness. Training for staff in the area of supporting residents proactively and positively in relation to behaviour had been delivered to 13 of the staff working in the designated centre at the time of the inspection.

While this was a positive step, the implementation of plans was not fully realised at the time of inspection, and these changes to policy and approach were not yet fully embedded into the day to day supports of residents. For example, some behaviour support plans addressed target behaviours such as pushing others, but did not yet include an assessment of the communication behind the behaviour and ensure residents' holistic needs were assessed and met in a proactive way to address it. Gaps were still evident in relation to the full use of a multidisciplinary approach to ensure residents' needs were responded to in a way that may reduce behaviour seen as a concern. For example, through referral to speech and language therapy, or sensory assessments by a relevant person.

Overall, inspectors could see improvements in the mind-set and direction of behaviour support in the organisation, but this was not yet resulting in tangible improvements for residents' quality of life.

Inspectors noted an improvement in some units in relation to the reduction of restrictive interventions, for example, reduction plans for routine medicine that was viewed as a restrictive intervention, the reduction of restrictive furniture, trial periods of doors being unlocked, and the removal of the use of sleep suits at night time. This improvement was not consistent across all units in the centre. However, there was an increased understanding of the need for review and clear rationale for the use of restrictive interventions.
Judgment:
Non Compliant - Major

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

Findings:
Inspectors found that overall, improvements were still required to ensure all residents' healthcare needs were well met, and residents were encouraged to have best possible health.

Inspectors found that residents living in the centre had a healthcare checklist completed within the last 12 months, along with an annual medical review with their General Practitioner. Inspectors found that there was a noted improvement in the standard of healthcare plans, which provided more guidance than previously to the reader regarding the best way to support residents with their identified needs. However, not all identified needs had written healthcare plans in place. For example, hypertension and arthritis. While there was a process of multidisciplinary team meetings which were now occurring more frequently, these did not include the review of healthcare plans and their effectiveness.

On review of written plans and observing practice inspectors found that some plans were not always followed. For example, a healthy eating plan indicating the requirement of mid-morning snacks, the provision of prune juice, and supper snack. Food diaries and monitoring records did not show that this was occurring for the residents.

Inspectors were concerned that the monitoring system in place by the provider to offer assurances that residents had adequate food and fluid provisions was not effective. Inspectors reviewed a sample of residents' records across the units for numerous dates, and found that for most, nutritional intake was not recorded after the main meal at 5pm, until breakfast the following morning. For some residents, this was a period of 16 hours without a recorded meal. This had been an issue raised previously, and the provider had amended the manner in which this was monitored. However, inspectors were concerned that the systems of oversight were still not effective at demonstrating that residents were offered nutritious snacks after their main meal. In talking with some staff, inspectors were informed that some residents were offered tea, hot chocolate or a biscuit but light meals and suppers were not prepared after the main meal in the evenings. Following the inspection, the provider undertook screening from a safeguarding perspective to investigate if adequate provisions were available.
Some meals were observed by inspectors in some units of the centre and found to be a much more social and relaxed event, with dining areas pleasantly laid out. Residents main meals were provided by the central kitchen on campus. In some of the units, staff told inspectors that they now had a slow cooker in the house, and were encouraging residents to try new food and recipes with themed nights which had been enjoyable. Inspectors found that in some units, meals were still being served through a hatch window. While attempts had been made to change this practice, residents were accustomed to receiving meals in this manner. Inspectors were informed by management that they had put in a written request for an open plan style kitchen to make the kitchen a more accessible room. From observation, there appeared to be a sufficient number of staff to support mealtimes, and the provider was aiming for each unit to put in place protected mealtimes.

Inspectors reviewed the supports in place for some residents with epilepsy and dementia. Inspectors were not satisfied that best practice was followed in relation to supporting a resident following the administration of as required medicine and continuing with activities of daily living.

As previously mentioned, inspectors were not assured that risk management in relation to supporting residents who were at risk of falls was effectively protecting residents from harm. Learning from an organisational review conducted by the provider had not been incorporated to ensure falls were effectively tracked. This coupled with the ineffective learning from incidents and care plans not being fully reviewed by the multidisciplinary team was not ensuring a holistic and comprehensive approach to care and support.

**Judgment:**
Non Compliant - Major

### 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:**
The inspectors found that overall, there had been improvements in the practice of medicines management, and that most of the actions from the previous inspection had been satisfactorily implemented. There were however, some areas that required further improvement.
For the most part, there were protocols in place for the administration of PRN medicine (medicines only taken as the need arises), that sufficiently guided staff to administer medicines appropriately. For one resident, there was no PRN protocol in place for a medicine used for pain management, and the maximum dose was not noted on the prescription record.

There were improvements required to ensure that the storage and disposal of medicines was secure and appropriate. In one unit, medicines for return to the pharmacy were not stored securely; loose, mixed tablets were stored in a plastic container, and could not be identified by staff on duty. This practice would not ensure that a pharmacist could confirm receipt of unused medicines. Some medicines did not have an expiry date on record.

While there were no residents self-administering medicine at the time of inspection, there were risk assessments and capacity assessments in place for each resident to determine the level of support required.

Judgment:
Non Compliant - Moderate

**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:**
Inspectors found that there remained non-compliances across the eight outcomes inspected, as evidenced in this report. While there were stronger management structures in place and an emergence of improved process and systems, there remained an absence of strong and effective management systems to deliver a good service in line with Regulations. While some improvements were noted, these had not resulted in positive and consistent changes in the quality of the care and support being offered to and experienced by residents.

The provider had conducted an annual review in 2017, inclusive of all services and
facilities offered by the provider. However, information in relation to this designated centre was inclusive of two pages, and did not fully comment on the quality and safety of care and support on offer. Unannounced visits had been carried out on behalf of the provider by an external auditor. While these were more consistently carried out, they did not always include qualitative information on key areas such as safeguarding, or the learning from incidents. Inspectors found that some actions raised at earlier visits, were still in need of address by the provider at the time of the most recent audits. Reports from unannounced visits were not aligned with the work of the management team in addressing non-compliances through the assurance reporting process, as a way to monitor the impact on the lived experience of residents. Inspectors found that the information in the unannounced audits was not clearly followed up on through line management process to ensure the relevant person was accountable at bringing about changes. For example, not always discussed at supervision meetings with local managers.

On review of the minutes of team meetings within the units, and wider meetings in the organisation, there was the absence of a link between issues arising locally for residents and the escalation through the lines of reporting and accountability in order to bring about effective change. This was most notable through reviewing the pathway of incidents.

Some team meetings reviewed occurred regularly and were well conducted, with agendas linked to residents' risk, safeguarding and premises with named staff responsible for certain actions and taking ownership of bringing about change. However, other team meetings were less frequent and minutes were limited in what was discussed omitting relevant events that could have been learned from, and did not bring about changes in practice. The benefit of meetings for residents was reliant on the direction of local managers, in place of a system guided by the provider.

Overall, inspectors found the governance and management of the centre was disjointed, with limited pathways to ensure accountability and to strive for better outcomes for residents.

**Judgment:**
Non Compliant - Major

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

Findings:
Inspectors were informed, and could see from documentation that the amount of staff working with residents had increased since the last inspection. In addition to the allocated staffing, the provider had put in place additional staffing through the use of agency staffing to facilitate some residents with dementia, and to ensure safeguarding plans could be followed more effectively.

Some local managers had put in business cases to receive funding for additional staffing, and in the absence of this the provider had ensured agency staffing was utilised to support some residents in a one to one capacity as mentioned above. In some units, a number of new staff had been hired. While these were positive responses, there was still a reliance of agency staffing to fully resource the centre. The staffing that was seen to be in place was based on responses to emerging care needs and safeguarding, in place of being based on a proactive assessment of residents’ individual and collective needs.

Although these improvements were noted, not all residents who had been assessed as requiring one to one staffing had this available to them. For example, one unit was staffed with one staff each day for three residents, one of which was deemed to need one to one support. In addition, in order to facilitate social outings and community integration, the current staffing levels were a challenge in some units. In some cases two staff were needed to accompany residents for a positive experience, and others needed one to one staff support, which meant that if two residents were to leave the center for an activity or outing, it would leave only one staff in the house with five residents. This was most notable in units that did not have day services or day activation available to provide occupation for residents during the day time, as these residents were reliant on their residential staff team to provide this support.

Some units had one consistent day activation staff who worked Monday to Friday from 9am to 5pm to provide an opportunity for activation during the day. For example, on the first day of inspection inspectors spoke with an activation staff who was supporting a resident to go swimming. In other units, this role was less consistent, and the benefits of it for residents were affected by training needs or annual leave of staff in question.

In speaking with staff and reviewing documents, inspectors found that some units were reliant on agency staff to work a night shift each night. There was evidence that this second night duty staff was not available on a night in May, with staff recording that they could not meet residents' personal care needs in the morning as there was only one staff on duty and residents woke early. Staff confirmed this, as sometimes there was issues with covering the shift if no agency staff were available. Staff informed inspectors that if agency staffing was not available they stayed on duty until one was arranged. While this finding seemed to be the exception rather than the rule, the planning of resources required review to ensure a stable and consistent workforce was available at all times to meet residents' needs.

Improvements were required to the planned and actual rosters maintained, in order to
easily identify who was on duty each shift. This was most notable when agency staff were covering shifts, as names were not included in planned or actual rosters so that management could easily verify who was on duty the previous night, and staff and residents informed of who would be supporting them during the shift.

Inspectors noted improvements overall in the provision of training to staff members. However, there were still a number of staff who required training or refresher training in mandatory fields. For example, five staff required training in manual handling.

Improvements were also noted in relation to the frequency of formal supervision with staff members, with formal supervision being recorded generally on a three month basis. Some units of the centre had routine staff meetings, with relevant discussions and clear action plans for staff. This was not consistent in all units of the centre, with some team meetings having a better focus on residents' issues, and learning from incidents that had occurred.

Inspectors reviewed a sample of staff files, and found that there was a system in place to ensure the requirements of Schedule 2 were in place. For example, proof of identify, references and Garda Síochána (police) vetting. The sample of files reviewed contained the required information.

As part of the six month assurance process, the provider had set themselves a goal to complete a competency assessment with all staff to identify areas of good practice, and areas in need of address and further training. In relation to this centre, all staff nurses had this assessment completed, and 12 care staff had also completed this.

Judgment:
Non Compliant - Moderate

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:

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Stewarts Care Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003902</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>17 and 18 July 2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>02 September 2018</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Residents were observed by inspectors to have minimal input into decisions regarding their day to day care and support.

1. Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

**Please state the actions you have taken or are planning to take:**
Residents views shall be sought in keyworker meetings, house meetings, multi-disciplinary meetings, complaints process and service user councils. Where residents cannot communicate their decisions verbally, the residents wills and preferences shall be considered. Additionally, the Speech and Language Team are commencing a program for developing total communication environments where necessary across the services, this will be rolled out over time to all service users whom require it. This will improve the overall communicative environment for residents, including exercising choice. Lámh workshops are commencing on the 5th of September to support staff in learning how to better understand and communicate with lámh users, these will run periodically depending on need and interest. A consultation clinic to allow quick and easy access to SLT support for non-complex cases is commencing on the 17th of September. These measures combined aim to support staff and service users to communicate with greater effectiveness, allowing for service users to affect greater change within their daily lives.

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/12/2018</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Individualised Supports and Care</td>
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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed task orientated practices in some units, and residents did not have opportunities to exercise choice and control in their daily lives.

**2. Action Required:**
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

**Please state the actions you have taken or are planning to take:**
Daily routines shall continue to be reviewed by the person responsible for the day to day running of the house, the residents and the staff team to ensure that practices are not task oriented. The registered provider shall communicate this across the support services. The importance of considering the impact of task practices shall be discussed at staff training, including safeguarding, behaviour support and communication training. Residents are consulted on meal options on a weekly basis at the residents meetings. The service provider shall continue to promote the preparation of meals within the home, through the availability of funding, training and creating opportunities for residents and staff to engage in preparing meals in the home, eg cooking competitions. The service provider has begun a review striving to have all meals prepared in homes. A program for developing total communication environments where necessary will commence across the services from 5th September, this will be rolled out over time to all service users whom require it. This will improve the overall communicative environment for residents, including exercising choice. Lámh workshops are
commencing on the 5th of September to support staff in learning how to better understand and communicate with lámh users, these will run periodically depending on need and interest. A consultation clinic to allow quick and easy access to SLT support for non-complex cases is commencing on the 17th of September.

**Proposed Timescale:** 31/12/2018  
**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Residents were not sufficiently supported to retain control of, and have access to their personal finances.

**3. Action Required:**  
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

**Please state the actions you have taken or are planning to take:**  
The finance policy has been reviewed and circulated. Residents will be supported to open their own bank accounts if they wish. The resident shall be supported to access their own personal finances in line with policy.

**Proposed Timescale:** 30/09/2018  
**Theme:** Individualised Supports and Care

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**  
Not all complaints were investigated promptly. Complaints escalated to the organisations complaints review team were not addressed in a reasonable time frame.

**4. Action Required:**  
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

**Please state the actions you have taken or are planning to take:**  
Complaints shall be responded in line with the policy. The Complaints Committee shall have oversight of the response time for complaints. Where complaints are not responded to in a reasonable time frame, the rationale for this shall be reported to the Complaints Committee for discussion, learning and improving.

**Proposed Timescale:** 10/11/2018
### Outcome 06: Safe and suitable premises

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The centre required maintenance in a number of areas, including damaged walls, broken radiators and broken blinds. Some rooms required painting.

#### 5. 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:**
Regular maintenance audits shall take place to ensure the area is in a good state of repair. Where maintenance requests are not completed, the rationale shall be communicated to the person responsible for the day to day management of the house.

**Proposed Timescale:** 30/10/2018

#### 6. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

**Please state the actions you have taken or are planning to take:**
Where maintenance issues directly impact a resident’s quality of life, the person responsible for the day to day running of the home shall advise the maintenance department to ensure the prompt repair or replacement where necessary.

**Proposed Timescale:** 30/09/2018

#### 7. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

**Please state the actions you have taken or are planning to take:**
Matters set out in schedule 6 shall be provided.

**Proposed Timescale:** 30/09/2018

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**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was an absence of robust risk management systems in the designated centre to effectively identify, assess and manage risk to promote residents' safety.

Learning from the review of accidents, incidents and near misses was not evident, and bringing about positive changes for residents.

**8. 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:**
a. An external review of risk management processes within the organisation shall take place.
b. All local managers shall be trained on the identification, assessment and management of risk.
c. The Risk Management Policy shall be reviewed.
d. A Head of Risk and Quality has been appointed as of 03/09/2018 to oversee risk within the designated centre and the organisation.

**Proposed Timescale:** 31/12/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Means of escape were not adequately maintained; some emergency exits were blocked by items. Others were locked and no key was available.

**9. Action Required:**
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for
maintaining of all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
A fire audit has been carried out and all actions implemented, all emergency exits are now fully maintained. Fire checks are carried out daily by the responsible person. Regular fire checks and compliance audits shall be carried out by the provider to ensure exits are maintained and accessible.

**Proposed Timescale:** 30/09/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Personal evacuation plans for residents did not provide sufficient guidance to ensure that they could be evacuated, and brought to a safe location in the event of fire.

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

**Please state the actions you have taken or are planning to take:**
Personal evacuation plans shall be reviewed and tested to ensure they provide sufficient guidance for the evacuation of residents to a safe location in the event of a fire.

**Proposed Timescale:** 30/09/2018

**Theme:** Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Not all staff in the centre had received training in fire safety management.

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

**Please state the actions you have taken or are planning to take:**
An audit shall take place to identify staff who have not completed fire safety management and those staff shall be trained.

**Proposed Timescale:** 30/09/2018
Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Supportive interventions were not always followed and fully implemented to the benefit of residents.

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

Please state the actions you have taken or are planning to take:
Incident reviews shall be carried out to consider the cause of the incident and identify if interventions were followed and alternative responses should have been implemented. Where necessary incidents of concerns will be brought to the attention of the Multi-disciplinary team for guidance. Where necessary supportive interventions recommended by clinical professionals will be discussed with the responsible person, keyworker or presented at the house meeting to ensure full and accurate implementation. Any learning from incidents will be discussed at staff meetings.

Proposed Timescale: 30/09/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an absence of identifying the cause of certain behaviours in an effort to meet residents' needs and alleviate behaviours of concern.

13. 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:
Behaviour support policy shall be reviewed and each behaviour support plan shall be reviewed in line with the policy.

Proposed Timescale: 31/12/2018

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
requirement in the following respect:
The provider was not taking appropriate action to ensure residents were protected from harm from peers.

**14. 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:
Where residents are subject to abuse, a safeguarding plan shall be put in place to consider all appropriate interventions. This shall include a review of accommodation. All residents shall be entered onto the DISMAT and submitted to the HSE to highlight the requirement for alternative accommodation.

**Proposed Timescale:** 30/10/2018

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. Some healthcare needs did not have associated support plans in place. In some instances, healthcare needs identified were not supported in the manner outlined in the healthcare plan.

2. Reviews of healthcare plans did not evaluate the effectiveness of the plan.

3. Some monitoring systems were not effective in recording the information they were intended to capture, and therefore could not provide assurance that the healthcare need was being sufficiently met.

**15. Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
Health care plans will be updated to ensure they guide staff practice.
Reviews shall evaluate the effectiveness of the plan.
The current monitoring systems in place to record food intake, have been significantly redeveloped. Nutrition screening, using the validated screening tool MUST, will identify residents who are malnourished or may potentially be at risk of malnutrition. All individuals identified at nutritional risk using the MUST Scoring system, will be referred to the dietitian for individualised nutrition assessment. All individuals identified as potentially at risk will have a therapeutic intervention commenced, and outcomes monitored monthly. Training has been completed, including guidance on how to complete the MUST Scoring system and guidance on the appropriate actions to take. Dietetic support/training around this new process is ongoing.
Food Record Charts will only be used as a dietary assessment tool where necessary.
These records will be individualised, comprehensive and used over a short time period. They will be used to demonstrate individualised care planning and will be used only in individuals with complex nutritional needs. Food & Fluid Frequency Charts – is a new initiative that will be introduced and will be completed daily for all clients. Food & Fluid frequency Charts provide a global, general observation on meal, snack & fluid frequency. Trends of adequacy in addition to changes in usual eating patterns will be identified and appropriate actions taken. To aid in the overall improvement in the provision of dietetic care an additional basic grade dietitian shall be recruited.

Proposed Timescale: 31/10/2018

**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:**

PRN protocol was not in place for one resident, and the maximum dose for one PRN medicine was not recorded on the prescription record.

**16. 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:**

The person responsible for the day to day management of each of the homes shall ensure that there is a protocol in place for each PRN medication and that the maximum dose is recorded on the prescription record.

Proposed Timescale: 30/09/2018

**Theme:** Health and Development

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

Returned medications were not securely stored, unidentifiable medicines were stored in Tupperware box.

**17. Action Required:**

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national
legislation or guidance.

Please state the actions you have taken or are planning to take:
All containers for medication to be returned shall be labelled as such. All containers shall be stored securely as per policy. Clarification shall be sought from the pharmacy regarding requirement to label medication for destruction and their recommendations shall be followed.

Proposed Timescale: 05/09/2018

Outcome 14: Governance and Management
Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Management systems and oversight had not been sufficiently strengthened to ensure the service delivered was of good quality, safe, in line with residents' needs and meeting the requirements of the Regulations.

18. 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:
Management systems will continue to be reviewed to ensure they are sufficiently robust to ensure good governance. This shall include; regular executive management and care management meetings; reviewing and training on the supervision process to ensure that it addresses staff underperformance; outsourcing registered provider audits to ensure that they are independent; ensuring all responsible persons have a management qualification and carrying out competency assessments with all staff.

Proposed Timescale: 31/12/2018

Outcome 17: Workforce
Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The number of staff working in the centre required review to ensure it was meeting the individual and collective needs of residents.

19. 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 required staffing complement has been reviewed. A recruitment campaign is ongoing to fill vacant positions. In the interim, agency staff are used to fill gaps on the roster. A protocol has been developed for booking of agency staff. This has been communicated to all local managers and is being monitored by the Workforce Planning Manager.

| **Proposed Timescale:** 30/09/2018 |
| **Theme:** Responsive Workforce |
| **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** |
Planned and actual staff rosters were not well maintained and did not clearly show who was on duty during the day and night.

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

**Please state the actions you have taken or are planning to take:**
All local managers shall be instructed to maintain actual planned and actual rosters for their area on a given day. An audit shall take place to ensure this is implemented.

| **Proposed Timescale:** 30/09/2018 |
| **Theme:** Responsive Workforce |
| **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** |
Not all staff had accessed mandatory training or additional training suitable to the needs of residents and their supports.

21. **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:**
An audit shall take place of training needs within the designated centre. Where staff are identified as needing training, they will be trained.

| **Proposed Timescale:** 31/10/2018 |