<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Mullaghmeen Centre 1</th>
</tr>
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<tr>
<td>Centre ID:</td>
<td>OSV-0005476</td>
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<tr>
<td>Centre county:</td>
<td>Westmeath</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<td>Registered provider:</td>
<td>Muiríosa Foundation</td>
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<tr>
<td>Lead inspector:</td>
<td>Andrew Mooney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Conan O'Hara</td>
</tr>
<tr>
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<tr>
<td>Number of vacancies on the date of inspection:</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 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: 06 December 2017 10:30
To: 06 December 2017 19:00

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 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</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 centres compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre’s for Persons (Children and Adults) with Disabilities) Regulations 2013. The designated Centre was inspected by the Authority four times under a different provider. This is the Authority’s first inspection of this Centre under the current provider the Muiríosa Foundation. The Muiríosa Foundation took responsibility for the operation of the Centre in August 2016. The inspection was completed over one day by two inspectors.

How we gathered our evidence:
Inspectors met with the five residents, staff members and the person in charge during the inspection. In addition, the inspectors met with family members who were present on the day of inspection. Inspectors reviewed practices and documentation, including residents' personal plans, incidents, audits, policies and procedures, fire management related documents and risk assessments.

Description of the service:
The service provider had produced a statement of purpose dated August 2017 which
outlined the service provided within this Centre. The centre is managed by Muiríosa Foundation and delivers services to adults with autism, mental health needs and behaviors’ of concern. The service provides 24-hour care to both female and male adults, aged over 18 years old. The centre comprises of two bungalows and each resident has their own bedroom. Bungalow one provides accommodation for four persons and consists of a sitting room, kitchen come dining room. Bungalow two is a three bedroom bungalow providing accommodation for one person. It consists of a living area, kitchen come dining room and sitting room. The two units of the centre are located in close proximity to another in Co. Westmeath.

Overall judgment of our findings:
Overall it was recognised that the new provider had made significant changes to the quality care and support of all residents in the centre, following a challenging period for all residents. For example the provider has successfully recruited a new staff team and person in charge to manage the service. These staff have developed a positive relationship with residents. The development of these relationships has promoted a culture of change and residents are experiencing a better quality of life as a result. This can be seen in the proactive measures taken to support residents with identifying and moving towards more suitable living arrangements of their choice.

Of the nine outcomes inspected, three were found compliant, three were found to be substantially compliant and three were found to be moderately non-compliant with the Regulations.

The findings are discussed further in the report and the areas for improvement are included in the action plan at the end of this report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

**Outcome 01: Residents Rights, Dignity and Consultation**

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Overall, residents living in the centre were consulted with regarding the running of the centre and there were systems in place to manage and respond to complaints. However, improvements were required to ensure all residents dignity was maintained at all times.

Residents in the centre were consulted on the running of the centre and meetings took place weekly. These meetings discussed activities, meals and health and safety issues.

Residents in this centre did not attend a separate day service and received an individualised (wrap-around) service. The centre completed an activity sampling programme for residents. However, from reviewing residents’ daily reports and from observations made on the day of inspection, inspectors found that residents had limited opportunities to engage in meaningful activities.

Inspectors found that there was a complaints process in place. The complaints process is user friendly and on display in a prominent place. Details of advocacy services were also on display in the centre.

However, inspectors found there was a malodour in some common areas in the designated centre, and found that this did not maintain residents dignity at all times. While, inspectors acknowledge that the centre had identified this as an issue and made some previous efforts to address it. It remained an issue for the people living in the designated centre. This was discussed with the area director and person in charge during the feedback meeting.
**Judgment:**
Non Compliant - Moderate

### Outcome 05: Social Care Needs

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

**Theme:**
Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The inspectors reviewed a sample of files and found that each resident had an assessment of need completed which included multidisciplinary input. However, improvements were required in the personal planning process.

There was a personal plan in place for each resident which outlined the person’s vision and the important things in the person’s life. Residents' person-centred plans outlined goals and objectives for residents to achieve. For example, growing family relationships and learning life-skills. However, inspectors found that while the personal plans were being regularly updated, they were not formally reviewed on an annual basis. Additionally, the effectiveness of the plans were not assessed, proposed changes were not recorded and those responsible for implementing the changes were not identified.

Inspectors found that residents were supported with transitioning to new placements in a planned manner. The inspectors reviewed a sample of transition plans in place for these residents’ and found that they and their representatives’ were involved in the transition process. Additionally, a transition plan viewed indicated that residents’ and their representatives’ had the opportunity to visit their proposed new centre.

**Judgment:**
Non Compliant - Moderate

### Outcome 06: Safe and suitable premises

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

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

Findings:
The inspectors identified areas of the centre which required some attention. This included painting and areas requiring some upkeep. These maintenance issues negatively impacted on the homeliness of the centre. The person in charge had identified these maintenance issues and provided evidence that they were liaising with the landlord to address these issues.

Judgment:
Substantially Compliant

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

Theme: Effective Services

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

Findings:
There was a health and safety statement in place dated September 2017. The health and safety statement outlined the roles and responsibilities of various members of staff and the arrangement in place for hazards and risks.

The centre had a policy in place for the management of risk dated December 2014. The policy included the arrangement in place to manage the four risks as specified in Regulation 26. The centre maintained a local risk register which outlined the risks in the centre and the measures in place to control the risks. The risks included fire, infections and slips trips and falls. In addition there were individualised risk assessments in place which included restrictive practices, dysphagia, manual handling and mobility.

The inspectors reviewed a sample of incidents and found that they were reviewed by the person in charge and followed up appropriately.

There were systems in place for the management of fire. There was adequate means of escape and fire exits were unobstructed. Break glass units containing keys were in place at all exits. The procedure for the safe evacuation of residents was on display in a
prominent location in the centre.

There was suitable equipment in place which was serviced appropriately. The equipment included ski sheets, extinguishers and an alarm panel. There were fire exit signs in place as well as appropriate emergency lighting.

The centre carried out regular fire drills. Inspectors reviewed a sample of fire drills and found that where drills identified concerns/issues, there were actions put in place to address them. Evacuation plans were in place for each resident which took into account the mobility and cognitive understanding of the residents’. Staff spoken with were also clear on the procedures in place in the event of a fire.

There centre had infection control procedures in place and there was hand wash and personal protective equipment available throughout the centre. There were arrangements in place for the disposal of clinical waste. However, improvements were required in infection control procedures. There was a lack of colour coded mop buckets which increased the risk of cross infection of an infectious illness which was a risk in this centre.

**Judgment:**
Substantially Compliant

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

**Theme:**
Safe Services

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

**Findings:**
The provider had ensured that there were measures in place to protect and safeguard residents.

There was a policy in place on the protection of vulnerable adults. The person in charge outlined the robust systems that would be put in place for the management of any allegations of abuse. Safeguarding concerns were managed appropriately and a local notification procedure had been agreed with HSE Safeguarding team. This was discussed with the person in charge and Area Director during feedback.

There was a policy in place in relation to restrictive interventions and where restrictions
were required, they were risk assessed. Restrictions were reviewed with appropriate allied healthcare professionals and in line with the Regulations. Where appropriate, residents’ engaged with the behavioural support team and had plans in place. The behavioural support plans guided staff practice and included proactive and reactive strategies.

Staff engaged by the inspector were knowledgeable and could describe their role in the safeguarding of residents. Staff could describe what constitutes abuse and what to do in the event of an allegation. The contact details of the relevant designated officer for the area were prominently displayed within the centre. Inspectors observed that residents appeared content and comfortable in their home and had a positive rapport with staff.

All staff had received training in the protection of vulnerable adults.

**Judgment:**
Compliant

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**Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

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

No actions were required from the previous inspection.

**Findings:**

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines dated September 2017. However, some improvements were required in the guidance on ‘as required’ (PRN) medications.

Inspectors found that medications were securely stored in the centre and divided into individual boxes. There were procedures in place for the return of out-of-date medication to the pharmacy. The inspectors viewed a sample of medications and found that medication was stored appropriately. There were no controlled drugs in use in the centre at the time of this inspection.

A sample of prescription and administration sheets were reviewed by the inspectors, and were found to contain the relevant information.

All staff were trained in the safe administration of medication. Inspectors were informed that only staff trained in this area, were allowed to administer medications.

There were protocols in place to guide staff practice for the use of ‘as required’ (PRN) medication. From the sample viewed, inspectors found that these required additional
information to appropriately guide staff in the administration of ‘as required’ (PRN) medication. This had also been recently identified by the person in charge.

Residents did not self-administer their own medication. However, an assessment of capacity had been completed regarding this for each resident, which outlined the rationale for this.

**Judgment:**
Substantially Compliant

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a statement of purpose in place which described the service being offered.

Some changes were required and these were discussed throughout the inspection and at feedback. These changes were made by the provider and submitted to HIQA after the inspection.

**Judgment:**
Compliant

**Outcome 14: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

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

Findings:
This inspection found that there was a clear management structure in place which identified the lines of authority and accountability in the centre. There was a full-time person in charge in place who was a suitably skilled, qualified and experienced manager.

Regular staff meetings were held and minutes were kept of these meetings. A sample of agreed actions from the meetings reviewed by the inspectors had been implemented. The person in charge reported that there were also regular meetings between the person in charge and the area director.

Staff had quarterly meetings for their first year of service and annual appraisals thereafter. Staff spoken with noted that they felt support by the person in charge.

Audits had been conducted in the management of medication, infection control, health and safety and monthly fire register.

There had been two six monthly unannounced visits on behalf of the provider in the last 12 months, as required by the regulations. The provider had also completed an annual review dated 2016, which showed evidence of consultation with residents’ and their representatives.

The person in charge was suitably qualified, skilled and experienced. She was knowledgeable regarding the requirements of the regulations and had detailed knowledge of the health and support needs of the residents. The Person in Charge was clear about her roles and responsibilities and provided evidence of continuing professional development.

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
The staffing levels in the centre at the time of the inspection were not in line with the statement of purpose for the centre and there was limited contingencies in place to cover staff leave and vacancies. Improvements were also required in the actual rota maintained in the centre.

Rosters reviewed, identified 19 shifts being covered by relief or agency staff in a four week period. The staffing levels within the centre were impacting on the assessed needs of residents and were not promoting staffing continuity within the centre. The person in charge also identified that on occasions, not all parts of the roster could be filled. During these periods the person in charge indicated she would fill part of these shifts to limit the impact on residents.

There was a planned and actual rota maintained in the centre. At times it was difficult to ascertain the duration of staff shifts, as the document did not reflect the practice within the centre. For example sleepover staff were not recorded on the roster between the hours of 11pm and 8am, despite still being onsite. Additionally, it was not always clear which staff worked on any given shift. At times relief or agency staff were not always clearly marked on the roster.

Staff training records were reviewed during the inspection, found that all staff had completed mandatory training. Additional training provided to staff included training in person centred planning, food hygiene and health and safety. These training records also included relief staff. Additionally, the person in charge provided documentary evidence of agency staff training records.

New staff and agency staff all underwent an onsite induction prior to working onsite and there was documentation to support this.

No volunteers were active in the centre.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Andrew Mooney
Provider’s response to inspection report

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<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Muiríosa Foundation</th>
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<td>Centre ID:</td>
<td>OSV-0005476</td>
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<tr>
<td>Date of Inspection:</td>
<td>06 December 2017</td>
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<td>Date of response:</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:
Not all residents' dignity was maintained at all times in relation due to a mal-odour in communal areas.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

**Actions Taken:**

- The Person in Charge has sourced new furniture, (in situ from 9.12.17)
- The Person in Charge has reviewed the cleaning rota to ensure the furniture is cleaned four times a day. This requirement has been communicated to the staff team at the staff meeting.
- The Person in Charge has commenced spot checks to ensure that the new cleaning rota is being completed.

**Proposed Timescale:** 09/12/2017

**Theme:** Individualised Supports and Care

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

While there were opportunities for residents to participate in activities, it was unclear if these were provided in accordance with known preferences.

**2. Action Required:**
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

**Actions Planned:**

- The Person in Charge will update activity planners with known preferences and will personalise same to suit each individual.
- The Person in Charge will introduce a new weekly activity tracker sheet that will be filled in daily.
- The Person in Charge and/ staff members will discuss new activities and development of valued roles with individuals at weekly resident meetings.
- Consultation with families will also continue and participation and engagement plans will capture any new learning or information.
- Feedback and learning on activities will be recorded in the Person Centred Support Plans in line with individuals’ goals and vision.
- Information sharing and review of activities and learning will be discussed at monthly team meetings commencing in February.

**Proposed Timescale:** 28/02/2018

**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:**

Personal plans were not formally reviewed on an annual basis to measure the effectiveness of each plan.

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

   **Please state the actions you have taken or are planning to take:**
   Actions Planned:
   - The Person in Charge will ensure that a formal personal plan review will take place for each resident annually.
   - This review will measure the effectiveness of the plan, the changes required and identify the person responsible for implementing these changes.
   - Changes as appropriate will be communicated to the staff at the January staff meeting.

   **Proposed Timescale:** 01/02/2018

**Theme:** Effective Services

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

The review of personal plans did not measure the effectiveness of the plans

4. **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:**
   Actions Planned:
   - A review of all Personal Plans will be undertaken by the Person in Charge.
   - The current document will be reviewed and amended if deemed necessary.
   - The amended document will assess the effectiveness of the plan, the changes required and the person responsible for implementing these changes.
   - The Person in Charge will ensure all staff are trained in the amended document.
   - The amended documents will be introduced to all staff by the Person in Charge at the February staff meeting.

   **Proposed Timescale:** 28/02/2018

**Theme:** Effective Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review of personal plans did not record proposed changes to plan, the rationale for changes and the person responsible for implementing these changes.

5. **Action Required:**
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:
Actions Planned:
- The Person in Charge will ensure that the amended review document will record the changes required, the rationale for these changes and identify the person responsible for implementing them.
- The Person in Charge will ensure all staff are trained in the amended document.
- The amended documents will be introduced to all staff by the Person In Charge in the February staff meeting.

**Proposed Timescale:** 28/02/2018

### 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:
In general there were a number of areas in the house that required attention.

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

Please state the actions you have taken or are planning to take:
Action Planned:
- Plan in place for work to be completed by June 2018

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

### 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 a lack of colour coded mop buckets which increased the risk of cross
infection of an infectious illness.

7. **Action Required:**
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Please state the actions you have taken or are planning to take:**
**Actions taken:**
- Colour coded mop equipment has been put in place on 9th January 2018.
- The use of the colour coded mop equipment was discussed at the January staff meeting on 12th January 2018

**Proposed Timescale:** 12/01/2018

**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:**
'As required' medication protocols required additional information to appropriately guide staff.

8. **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:**
**Actions Taken:**
- The Person in Charge has reviewed and developed a new PRN Protocol, to ensure it includes sufficient information to guide staff in the administration of PRN medication.
- All PRN protocols are signed by the residents GP.
- The new PRN protocol was discussed with all staff at the January team meeting.

**Proposed Timescale:** 12/01/2018

**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 available to the centre was insufficient to meet the needs of
9. **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:**

**Actions Taken:**
- Four new staff have been recruited and have commenced working in the designated centre (05.01.2018)
- There is ongoing recruitment of relief staff to mitigate the risk of unfamiliar staff working within the location.

**Proposed Timescale:** 5th January 2018 & Ongoing Recruitment to Relief Panel

**Proposed Timescale:**
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The rota did not clearly identify staff working arrangements in the designated centre as described within the body of the report.

**10. 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:**

**Actions Taken:**
- The Person in Charge will manually reflect sleepover shifts on the Roster.
- The Person in Charge will inform the Designated Centre when agency staff is covering an unplanned shift and this will be manually inputted into the working roster in each designated centre.
  (Actions in place with effect from 9th January 2018)

**Proposed Timescale:** 09/01/2018

**Theme:** Responsive Workforce

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was an over reliance on relief and agency staff which was impacting upon the continuity of care provided to residents.

**11. 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:**

**Actions Taken:**
- Four new staff have been recruited and have commenced working in the designated centre (05.01.2017)
- There is ongoing recruitment of relief staff to mitigate the risk of unfamiliar staff working within the location.
- The Person in Charge completes an induction with relief staff to ensure that they are aware of roles and responsibilities and the personal supports of each individual

Proposed Timescale: 5th January 2018 (Recruitment ongoing, Induction of Relief Staff ongoing)

**Proposed Timescale:** 05/01/2018