Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003727
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Mary Reynolds
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	17
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
27 January 2015 10:00	27 January 2015 20:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first monitoring inspection of this designated centre for adults with an intellectual disability by the Health Information and Quality Authority (the Authority). It took place over one day and reviewed seven of the outcomes required to demonstrate compliance with the legislation and regulations. The purpose of the inspection was to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

The centre is part of the Daughters of Charity Support Services Limited and provides care for female adults with moderate to severe intellectual disabilities and challenging behaviours. The accommodation consists of three individual purpose built houses accommodating 17 residents in total. It is situated on the grounds of a campus which provides care for up to 53 residents. There is also a day centre located on the grounds. Integral supportive governance systems included a clinical director, person in charge, quality control and risk manager.

The inspector met the service manager who is nominated to act on behalf of the provider , the centre manager and the acting person in charge. The inspector also met with residents and staff members. Residents who could communicate with the inspector indicated that they liked their home, the staff and the activities they took

part in.

Inspectors found evidence of a commitment to provide care for a complexity of residents' needs within a multidisciplinary framework and compliance with the regulations and standards.
There was access to a range of healthcare services including psychological and mental health specialists. Nutritional support was good and there was evidence of residents and relatives involvement and consultation in care practices. Safe guarding systems were in place. Staff were observed to be respectful, attentive and very familiar with the residents needs.

Areas for improvements were identified in the following areas:
Outcome focused personnel planning for residents
The development of a risk management policy
The appropriate use ,monitoring and review of restrictive practices
Supervision systems were required for staff.

The inspector discussed staffing levels with the provider at specific times and requested that they be reviewed to ensure they were satisfactory.

The non compliances are discussed in the report and the actions required are detailed at the end of the report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Residents had personal plans in place and there was evidence that these were reviewed consistently and at a minimum annually. There was evidence of multidisciplinary review and assessment by relevant clinicians and a detailed annual health care review was undertaken. Recognised assessment tools were used to access falls risks, mobility and dietary needs. Plans for clinical care were implemented and reviewed. There was evidence of relatives and or residents involvement in the planning and review process. Areas for improvements were required however, in that the plans focused primarily on healthcare needs and were not inclusive of resident's specific social, emotional needs and preferred routines. Planning for social care needs was minimal. This deficit includes those plans relating to maintenance of family contacts. It was very difficult to ascertain if these aspects of the personal plans were reviewed to ascertain the outcome for the resident. For example, a resident had identified a picnic as an activity she would like but staff could not state whether this had ever taken place. Some residents had pictorial scrapbooks detailing their activities and social contacts but these were primarily biographical. The inspector also found that care plans in relation to resident's loss and bereavement did not demonstrate an understanding of the residents capacity for grief following the loss of significant adults in their lives.

Staff in the units were observed to be attentive, available and present to the residents and social activities were implemented but some improvements were required. There was evidence observed of day-to-day strategies implemented including help with personal care and preparing meals, personal shopping where appropriate to the capacity of the resident, staff did hand and foot massage with residents and some residents had responsibility for small household tasks. The inspector observed that the televisions were tuned to colourful programmes or favourite DVDs of the residents were played.

Staff also took residents individually for walks on the campus.
The inspector was informed that most of the residents not have the opportunity for short holidays or overnight breaks away. There was a day service available on the campus which provided a range of activities including sensory work/ art and one to one time for residents. A review of the resident's activities records indicated that some residents had one hour a number of times per week to avail of this service which was limited.

Communication tools such as "passports" and pictorial images were used to outline the residents' care needs and preferences and these were very detailed.

Care is overseen via a number of processes including a multidisciplinary review held annually and to which relatives are invited. There was also a monthly core group meeting which is used to review the care provided. The inspector found that the requirement to ensure resident's needs could be met within the service and that the care was being effectively reviewed was not consistently evident however. This is detailed under Outcome 8 Safeguarding and Safety.

The documentation used for care planning was copious but did not act as an effective working tool for staff. For example, when a falls risks assessment indicated a high risk of falls, staff were referred to two further documents to ascertain the preventative actions to be taken. Review meeting records were not consistently dated therefore it was not always possible to ascertain the time frames for any action to be taken or if they had been completed. These matters were discussed with the provider and person in charge.

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):
No actions were required from the previous inspection.

Findings:
There was a signed and current health and safety statement in the centre and overall the inspector was satisfied that there were systems in place to promote the safety of the residents. However, the risk management policy required some improvement to ensure it met the requirements of the regulations in relation to the identification of potential risks and the systems in place to manage them. A risk register had been completed for the centre. A number of other policies were in place including missing residents, aggression and violence and an emergency plan. The emergency plan detailed the arrangements for the interim accommodation of the residents should this be required. A concise detail of each residents health and mobility status was located at the entrance to each centre should it be required by emergency services.

Entrance and exit doors and the rear garden doors were secured via key code or fob to prevent residents inadvertently leaving the centre or unauthorised access by other persons. Flooring was safe and where residents were deemed to be at risk of self injury appropriate padding was used on sharp edges to prevent injury.

Satisfactory fire prevention and management systems were in place in place with records demonstrating that fire alarms, emergency lighting and extinguishers were present and serviced quarterly and annually as required. Fire drills were held twice yearly with the resident included. Any issues identified were noted. Fire training was held annually and was up-to-date for all staff.
A number of vehicles were available to the centre. The inspector saw evidence of insurance and was informed that all had evidence of roadworthiness. Other equipment such as hoists and chairs were also serviced. There was an infection control policy in place and appropriate personal protective equipment was available.

Incidents are audited and reports indicated that the data was analysed for themes and emerging issues.

Judgment:
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):
This was the centre's first inspection by the Authority.

Findings:
The inspector reviewed policies and procedures for the prevention, detection and response to allegations of adult abuse and found that they were satisfactory and demonstrated an awareness of the role of external services and reporting mechanisms in this matter. Staff were able to articulate their understating and responsibility in relation to this. Other factors which support the protection of residents included the resident's forum meetings. There were procedural guidelines on the provision of personal care to residents. These were identified in personal care plans although they did not provide specific information to guide practice in terms of safe guarding and dignity for residents.

Records demonstrated that training in the protection of vulnerable adults had not been consistent with a number of staff out of date for a significant number of years. The inspector was informed by the person in charge that this was taking place for the

outstanding members of staff on the day of the inspection facilitated by a suitably qualified person. The person in charge stated that this training would in the future be mandatory for staff.

From a review of records, interviews and notifications forwarded to the Authority, the inspector was satisfied that the provider took appropriate action in safeguarding residents and reviewing any alleged incidents in a timely manner. Where appropriate a review by the social work and psychological services was undertaken as part of the internal screening process.
There was a policy on the management of behaviour that is challenging which advised assessment, review and management in the least restrictive manner. It also stressed the importance of understanding the meaning behind the behaviours for the resident. For example, anxiety regarding new places, changes to routines or noise levels. Improvements were required however in some aspects of practice in relation to this. A number of supportive strategies were seen to be in place and outlined for individual residents. Staff were familiar with them, could identify individual triggers and the supportive strategies or routines which were helpful.

Some restrictive procedures were utilised which primarily included some locked doors, or the use of special clothing. There was evidence that these were reviewed and alternatives or removal of the restriction was tried. A number of safety features were used including belts on wheelchairs for safety reasons and these were appropriate to the needs of the residents. There were behaviour support specialist's available and clinical supports available within the organisation.

However, significant improvements were required in the implementation of other restrictive practices, namely the use of single separation as a result of behaviours. The inspector acknowledges that the initial decisions regarding these were made as a response to crisis and risk to self and or other residents.

There was some evidence that in one instance that the arrangement had had a positive impact on the behaviour, and a reduction in the use of psychotropic medication. There was also a defined plan to ensure the resident had a change of environment and had a walk twice daily. The resident had access to a sensory room once at weekends when other service users were not using the day centre as it is quieter at that time. It had been recommended by the multidisciplinary team that such a space would be made available within the living environment which would be more easily accessible to the resident. This had not been followed through.

The inspector could not ascertain if the actual living environments in themselves had been assessed for suitability and impact on the residents. One of the living environments was created by dividing a section within one unit where a resident had access to a small living area and bedroom behind locked doors. The doors contain glass panels for viewing and so the resident can view the activities of staff and other residents. However access to the bathroom is within the unit and other residents also use this area for sleeping. It was reported that noise and activity distress the resident which resulted in challenging behaviours. Another area was designated at the back of the daycentre which was used from early morning until late at night for a resident. Records seen by the inspector indicated that up until very recently there was no activation or change of

environment for this resident with one staff assigned daily to provide care and support. The living space which the resident had access to was a single room and shower/toilet within the day-centre which contained very little furniture and was bleak in appearance.

The inspector saw some recent records where consideration was being given to the addition of second room for activation and some small changes were being introduced such as to allow brief contact with other residents. The provider also informed the inspector that they were in the process of reviewing the resident's care placement. The inspector was not satisfied that these arrangements, one of which had been in place for three years had been adequately reviewed or intervened with from an environmental, therapeutic or rights perspective in that time.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
The inspector found that the healthcare needs of the residents were met to good standard. There is a contracted general practitioner (GP) who is present regularly in the centre and also on an as required basis. Out of hours service is also available. Medical records and nursing notes reviewed showed that there was regular review and a prompt response by staff to any changes in resident's health status. A detailed composite annual medical health review was also undertaken which included all underlying medical conditions and interventions.
There was evidence of regular access to opthalmatic services, hearing specialists, and dental and chiropody services available. Referral and regular consultation with allied services as required by the residents, including physiotherapy, occupational and speech and language therapy was seen to be available. These services are integral to the service. Gender specific health checks were also undertaken where this was feasible for the residents. Clinical overview by psychiatric and psychological services were available to residents and to staff in an advisory capacity. Routine monitoring of health was undertaken including blood sugars, weight, blood pressure and blood tests where required.

There were care plans to guide staff in the management of some fundamental medical conditions including the management of epilepsy, during and following a seizure.

There was a policy to guide practice on-end-of-life care. No residents in the centre required care planning in relation to this at this time and there were no advanced decisions made in relation to the residents. The inspector was informed that in the event

of illness this would take place in consultation with the resident's next of kin and palliative care support was accessed as required. As the residential service had twenty-four-hour nursing care, end of life care can be provided in the centre if this is the wish of the resident and or relatives.

All meals were prepared in a central kitchen although each unit has a kitchenette equipped for food preparation and storage. Breakfast and snacks are prepared in the units. Some of the residents helped staff to prepare food and staff also shopped locally for individual treats the residents liked. The food was seen to be nutritious and varied. Dining areas were homely and pleasant in décor.
The inspector observed that there was a sufficient variety of snack food and drink available and resident's requests for drinks and food were met by staff that were very familiar with their likes and dislikes. The mealtime experience was observed to be enjoyable, social and staff were seen to assist residents slowly if this was required. However, it as noted that due to staff breaks and the need for one staff to attend to a resident staying in another section of the complex for meals, only one staff and one housekeeping staff was available to assist the residents at this time. The provider agreed to review this.

Judgment:
Substantially Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The current medication management policy had recently been revised and was satisfactory and in accordance with legislation and guidelines.

There was evidence that medication was being reviewed regularly by the appropriate practitioner whether mental health or general and a consistent reduction in the use of psychotropic medication was evident in some instances. No residents were assessed as suitable for self-administering medication at the time of inspection. Training for staff in medication management was not routine.
A review of a small number of errors indicated that they consisted of staff not signing the administration records and this was dealt with via access to training. Audits of medication took place which also included the pharmacist. There was a documented check on the receipt and return of medication and safe storage systems were evident. There were no controlled medications being administered at the time of this inspection.

Judgment:
Substantially 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):

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

Findings:

Overall inspectors found that governance arrangements as implemented were satisfactory and implemented. The operation management team in this instance consists of the overall service manager and nominee of the provider and a centre manager who has responsibility for all services on the campus. There was an acting person in charge at the time of this inspection. The managers spoken with demonstrated an understanding of their respective responsibilities and the regulations and all are engaged full-time in their posts. There is some additional support for the person in charge with 1.5 clinical nurse managers (CNM)1 available on a day to day basis.

The management team was also comprised of a clinical director, quality assurance and risk manager. There were two clinical nurse managers grade 111 who oversee day-to-day practices in the houses. Reporting structures are clearly defined. Staff were clear on the management structure, reporting systems and areas of responsibility and residents were aware of the local mangers. There is an on call system for out-of-hours. Regular meetings take place at various levels including meetings with the service manager, the person in charge and provider nominee. A brief review of the records demonstrated that these were focused on safety and care for residents.

A number of processes were used to monitor and oversee the safety and quality of care. These included the undertaking of monthly and annual reviews of accidents and incidents from which remedial actions were identified and monitored for compliance and an annual review of the quality of care and twice yearly safety audits of the units. The person in charge also maintained details of accidents and incidents which could be seen to be reviewed as they occurred.

Judgment:

Substantially 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):
This was the centre's first inspection by the Authority.

Findings:
The inspector was satisfied from observation and records available that both the skill mix and numbers of staff was satisfactory to meet the needs of the residents with some review required. There was a total of 28 staff employed in the centre. A small number of agency staff are used but the inspector was informed that the personnel used are consistent and assigned to each unit to ensure continuity of care.

There were either one or two nurses assigned to the units during the day. Nurses were also present in two of the units at night in order to ensure delivery of appropriate care to residents who require this. As stated in Outcome 11 at meal times, the ratio of staff was depleted with housekeeping staff assisting residents. A review of the rosters showed that in two units on occasions the ratio of staff decreased to one staff from 18:00hrs until 20:30hrs. This occurred in a unit where a resident was in single separation and there was also a resident with a significant falls risk. The inspector had no evidence that this impacted negatively on residents care at this time, however this was discussed with the provider who agreed to review this.

A review of the training records available indicated that training in the moving and transporting of residents was not up to date for a number of staff. As care plans required the use of a hoist for some residents in the event of a fall this finding is of concern.

Additional training pertinent to the residents need had taken place for some staff in the management of behaviour and autism. A small number of staff had undertaken food safety training and the inspector was informed that this was planned for 2015.
The documents and procedures for the safe recruitment of staff had been reviewed by the Authority at a previous inspection within the organisation and found to be satisfactory. The evidence available to the inspectors did not demonstrate that staff had an on-going supervision system in place although there was an annual appraisal system. Policy was forwarded to the Authority following the inspection. The inspector did note that where issues required intervention by the person in charge this was attended to and that where medication errors were noted staff were required to undertake additional medication management training although this was not undertaken routinely.
Staff meetings were held and staff were found to be knowledgeable on the needs,

routines and preferences of the residents.
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:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003727
Date of Inspection:	27 January 2015
Date of response:	19 February 2015

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not reflect residents social and emotional care needs.

Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the

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

resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
Personal plans will be reviewed to ensure they include residents social and emotional care needs.

Proposed Timescale: 30/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Review records did not demonstrate that the outcome or effectiveness of the plan was reviewed.

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:
Personal plans will be reviewed to assess the effectiveness of each plan and take into account changes in circumstances and new developments.
A person has been appointed to review all careplans in conjunction with keyworkers.

Proposed Timescale: 30/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Significant restrictive procedures used had not been adequately reviewed.

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:
An external consultant with expertise in the area of autism will review the current restrictive practices in place for people living in single separation arrangements and make recommendations regarding future needs

Proposed Timescale: 30/05/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence that alternatives to restrictive procedures and the duration of them was considered.

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:
All restrictive practices in place will be reviewed by MDT to identify least restrictive option possible. An external consultant with expertise in the area of autism will review the current restrictive practices in place for people living in single separation arrangements and make recommendations regarding future needs

Proposed Timescale: 30/05/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Procedures for the provision of intimate care did not guide practice.

Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
Intimate Careplans will be reviewed to ensure they provide staff with clear directions in how to support an individual with personal care in a dignified manner.
A person has been appointed to review all careplans in conjunction with keyworkers.

Proposed Timescale: 30/05/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have up to date training in moving and transporting residents and medication management.

Action Required:

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

Please state the actions you have taken or are planning to take:
1. All staff will receive refresher training in moving and handling and a plan has been agreed with the training department for 2015.
2.All nursing staff will complete the online HSE land training in medication management.
3.The service pharmacist will provide information sessions on medication safety issues to staff.

Proposed Timescale: 30/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no formal staff supervision system in place.

Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Please see factual accuracy report and copy of staff supervision guidelines attached

Proposed Timescale: 19/02/2015