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 Health Service Executive
Centre ID:	OSV-0002463
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Angela O'Neill
Lead inspector:	John Greaney
Support inspector(s):	Aoife Fleming; Breeda Desmond; Liam Strahan; Noelle Neville; Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	30
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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
04 August 2015 08:00	04 August 2015 19:30
05 August 2015 09:00	05 August 2015 18:30

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

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

Summary of findings from this inspection

On 6th November 2015, HIQA took the unprecedented step of applying to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities. The centres were St Raphael's Residential Centre, Oakvale and Youghal Community Hostels, all located on the grounds of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

This report relates to an inspection of Oakvale, one of the nine inspections of these centres during 2015 which identified serious concerns in relation to safety of residents and poor quality of life for residents. As a result of poor governance and

oversight of the centres, management had failed to identify these issues for themselves, failed to address them effectively and failed to ensure a safe and good quality service for residents.

This inspection was triggered by the receipt of a notification to the Authority by the provider regarding an allegation of abuse towards a resident. As part of the inspection process, inspectors met with residents, the person in charge (PIC), the Provider Nominee and other staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, and policies and procedures.

Overall inspectors found evidence of significant failings by the provider in ensuring that all residents were protected from abuse. Inspectors had serious concerns in relation to all areas inspected including inadequate safeguarding practices and procedures, ineffective governance and management arrangements and insufficient staffing.

Inspectors were concerned regarding the serious risk to residents' protection, health and welfare. The governance arrangements continued to be inadequate with significant deficiencies in the management of incidents, in the safeguarding of residents, lack of positive behavioural supports, inadequate staffing levels and training.

On the first day of inspection inspectors required the provider to take immediate action in relation to:
1. There were inadequate arrangements in place to protect residents from all forms of abuse.
2. The governance and management arrangements did not ensure that the service is safe, appropriate to the residents' needs, consistently and effectively monitored.

Inspectors were not satisfied with the response to the action plans and the concerns of HIQA regarding the inadequate response was relayed to the provider at a meeting which was held at the Authority main offices a week after the inspection.

The action plan at the end of the report includes the immediate actions which were issued. The action plan also outlines the areas of non-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 2013.

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:
Not all residents in the centre had the opportunity to participate in meaningful activities. For example, one resident received activation only on one day a week and staff informed inspectors that several residents in one bungalow did not attend any external activation. The residents were observed by inspectors spending long periods of the day without activation or stimulation. Staff informed inspectors that there were insufficient staff to facilitate residents on trips out of the centre or to engage residents in meaningful activities in the centre. On reviewing the personal plans of residents, there was no evidence that residents engaged in their own specific interests outside of the centre. For example, residents who were identified as enjoying swimming were not facilitated to engage in this activity. Inspectors were told by staff, and saw documentary evidence, of staff requesting extra staff from management to support residents in activation; however these requests had not been sanctioned.

While there were residents' meetings as part of the arrangements to consult with residents, inspectors found that these did not provide residents with an effective consultation process. Inspectors viewed the minutes of residents' meetings. Resident meetings were not held regularly in all bungalows of the centre with a gap of four months found between residents' meetings in one bungalow. The follow up and actions of meetings were not always recorded, there was no plan to identify what actions needed to be addressed, when or by whom. There was no evidence to indicate that the minutes of previous meetings were discussed and resident satisfaction was not documented.

Most residents in this centre had single bedrooms. On the last inspection the provider

told HIQA that screening would be provided between the beds in twin bedrooms to protect resident privacy and dignity, especially when providing personal care. However, this action had not been addressed despite the provider outlining in their response to the previous action plan that this would be completed by 15/06/2015.

The complaints policy did not reflect practice in the centre as the nominated complaints officer no longer worked in the centre. The complaints process stated that the "Director of Nursing/Deputy" will receive and acknowledge all complaints. However, this person was not named and their contact information was not provided for residents, relatives or visitors. There was no complaints log or record available on some bungalows and staff told inspectors that they did not have one. The small number of complaints viewed in the complaints log of a bungalow did not record the satisfaction of the complainant with the outcome of the complaint, as required by the regulations. Complaints had been recorded by staff members in relation to the lack of resident activation and the shortage of staff which the complainant believed was impacting on resident's care needs. The outcomes of these complaints had not been documented in the complaints log.

The inspectors saw that the contact details of an independent advocacy service were on display in the centre. Contact with the advocacy service had been made by staff on the behalf of some residents.

Judgment:
Non Compliant - Major

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

Theme:
Individualised Supports and Care

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

Findings:
A communication assessment form was in place in residents' notes. However, this assessment form was not completed comprehensively for all residents with many questions unanswered in the sample of assessment forms viewed by inspectors. There was inadequate detail in the personal plans about how residents' communication needs were to be met. Inspectors saw assessments in residents' personal plans which indicated how residents communicated but there were no guidelines for staff on how to communicate with the residents in their preferred mode. Some residents used sign language and staff did not have adequate understanding of the signs used by the residents.

The positive behavioural support plan recommended the use of specific cards with signs

and symbols to support communication. However, staff were not trained in these communication support methods and there was no evidence of communication aids, equipment or assistive technologies in use to support residents communication or to promote their full capabilities. There was no evidence of external professional input into meeting residents' communication needs in any of the residents' communication assessments or personal plans.

Judgment:
Non Compliant - Major

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

Theme:
Individualised Supports and Care

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

Findings:
Relationships between residents and their families were supported and there were facilities in this centre for residents to receive visitors in private in each bungalow. Evidence of efforts to contact residents' families and involve them in the development of residents' care plans was seen.

Inspectors reviewed a sample of recording sheets which documented staff contact with residents' family/next of kin. Inspectors found that families were not being kept informed about all important events and incidents in the centre.

While some residents were facilitated to develop and maintain links in the community however, these were predominantly residents who could self-advocate. Many residents did not engage in activation or have links external to the centre or in the community.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The centre's policy for admissions and discharges did not outline the procedures in place for admitting residents to the centre as required by the regulations. Inspectors reviewed records and found that the provider was not keeping adequate accounts of the admission of residents to the centre.

Inspectors found that the contracts for the provision of service were not adequate. Many were not signed by the provider, and some had not been signed by the resident or their representative. The contracts did not use the name of the designated centre, but used the name of another designated centre on the same campus. Fees for additional charges to residents were not outlined in the contracts.

Judgment:
Non Compliant - Major

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:
Of the sample of residents' personal plans reviewed, there were comprehensive assessments in place for some residents. However, there were significant blanks in the assessments for other residents. There was inconsistency in the completeness and implementation of personal plans between the bungalows of the centre.There was no evidence that the effectiveness of personal plans were being reviewed as required.

Some personal plans contained information on residents' likes, dislikes, what changes they would like to see in their routine or care. However, there were no action plans outlining who was responsible for facilitating the residents' wishes, strategies for implementing supports and services to enable the resident to achieve a good quality of

life and realise their goals and no timelines for action were recorded. For example, inspectors saw where residents had identified interests in such activities as gardening and swimming but residents were not being facilitated to participate in these activities. In one example, the resident's hobbies and interests checklist did not set out any activities which resident liked, but ticked fourteen activities which the resident disliked.

Inspectors saw evidence where no personal plan had been developed to guide staff in the care and support of residents even though residents were in the centre for many years.

Judgment:
Non Compliant - Major

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, this centre was found to be clean and bright and well maintained.
However, the following actions which the provider had committed to following the last inspection were not addressed:
- there were no screens between the beds in twin bedrooms to protect residents' privacy and dignity
- residents in twin bedrooms continued to share a wash-hand basin
- inappropriate storage arrangements for medication trolleys, with the medication trolleys still stored in the quiet room/ visitors room
- there was only one sluice room in the locked bungalow of the centre which meant that staff had to transport items for sluicing between bungalows.
Suitable arrangements for the safe disposal of clinical waste are required under Schedule 6 of the Regulations.

The overall appearance of one of the bungalows was clinical and did not provide a homely environment for residents as outlined in the statement of purpose.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
While the centre had a risk management policy which met the requirements of the Regulations, there were inadequate risk management arrangements to ensure the safety of residents.

Six of the actions from the last inspection had not been addressed.

There were inadequate systems in place to investigate and learn from incidents in the centre. The incident forms did not provide enough space for staff to record the details of incidents occurring in the centre comprehensively. The system for reporting incidents to management, and for implementing actions and improvements as a result of incidents was inadequate.

The provider's audits of incidents in the centre were viewed by inspectors. They collated the types of safeguarding incidents per resident, per bungalow (aggression to staff, resident on resident incidents, unexplained bruising, resident absence without leave). However, there was no evidence of learning or actions to improve the safety of resident care as a result of these audits.

Large drums of laundry detergent were stored unsecured in linen rooms; this practice had not been risk assessed and posed a risk of injury to residents, especially residents with Pica.

There were no safety statements available in the bungalows.

The procedures around sluicing in the centre continued to be inadequate and posed a risk of infection to residents as there was only one sluice room in the centre which was located in the locked bungalow. Items from other bungalows had to be transferred to this bungalow. Staff informed inspectors that they had on occasion in the past conducted manual sluicing in the residents' bathrooms where there was no sluice machine or bed pan washer. This arrangement did not protect residents from the risk of infection and cross contamination.

Since the last inspection, external smoking sheds had been put in place to protect residents from accidental injury. However, the smoking policy was inadequate as it did not address the arrangements for protecting residents, observing residents when

smoking or the storage of cigarettes and lighters. Inspectors saw risk assessments for smoking that were contradictory in places and did not adequately give guidance to staff on ensuring the safety of residents.

Fire alarms and fire equipment were serviced as required. However, the actions that the provider undertook to complete at the last inspection regarding fire safety were not implemented. Daily checks of the fire equipment and fire exits were not being conducted. Regular fire drills were not being conducted and the staff on the locked bungalow informed inspectors that a fire drill had not been conducted. Not all staff had up to date fire training. A number of fire doors were held open with door wedges, which was not in keeping with fire safety procedures. The use of door wedges in designated fire doors prevented such doors from functioning as fire doors in the event of a fire. Of particular concern was the fire door in the kitchen (which is a room with a significant fire risk) of one bungalow was wedged open and was not fit for purpose as it was stiff, heavy and very difficult to open.

The residents' personal emergency evacuation plans (PEEPs) in place were not adequate. There was inadequate detail to outline the individual capabilities of residents to comprehend and respond to the fire alarm, and the staff requirements to support individual residents in this regard were inadequate.

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:
This inspection was a triggered inspection in response to the receipt of a notification by the provider to the Authority of an allegation of abuse of a resident by staff members. Following receipt of the notification, HIQA required the provider to immediately submit a safeguarding plan to HIQA. During the inspection, it was found that one of the core arrangements in the safeguarding plan relating to staffing arrangements had not been implemented. Inspectors were informed by the provider that, due to industrial relations

considerations, they could not implement this central component of the safeguarding plan. In addition, this information was not voluntarily provided but inspectors were only made aware of the non-implementation of these safeguarding measures after making enquiries to local management during the inspection.

Inspectors found that the safeguarding procedures and measures to protect residents from all forms of abuse were inadequate. Inspectors noted that there were a number of existing risk factors in the centre that increased the potential for abuse to occur. These risk factors included inadequate staffing levels, staff competencies did not match service requirements, lack of staff training in safeguarding and inadequate governance and management.

There were numerous on-going incidents of resident-on-resident physical altercations and unexplained bruising in several bungalows. Management did not implement appropriate safeguarding measures to protect residents. There were inadequate systems to ensure that each incident was effectively managed including notifying management to ensure the necessary safeguarding actions were identified and implemented. Inspectors found evidence that reporting obligations as required under Regulation 31 Notification of incidents were not met.

In addition, other safeguarding responsibilities including conducting preliminary screening and further investigations were not implemented for all incidents of potential abuse.There were a number of residents who were frequently involved in these altercations and inadequate actions to protect these residents were taken.

Inspectors reviewed the safeguarding plans for residents and found that they were not being implemented consistently. In some instances, they were not implemented because there were inadequate numbers of staff working in the centre on those days. Due to a reduction of staffing at night time, the safeguarding plans could not be implemented at night time. Staff informed inspectors that they had concerns regarding the lack of staff and activation to adequately safeguard residents who they believed were at risk of assaulting other residents.

The safeguarding policy was not up to date as the designated person responsible for accepting safeguarding concerns referred to in the policy no longer worked at the centre. The policy did not reference the 2014 Health Service Executive (HSE) Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures. The centre's policy identified unexplained bruising as abuse. However, in practice such incidents of unexplained bruising were not identified, reported or managed as potential incidents of abuse.

Staff training records were viewed by inspectors and, as identified on the last inspection, not all staff had up to date training in the protection of vulnerable adults. A number of staff, including management staff, were interviewed by inspectors. Inspectors found that there was an insufficient knowledge of what to do in the event of an allegation or suspicion of abuse.

Inspectors reviewed the policies and practices around restraint and found that restraint measures were not being managed appropriately. Bed rail assessment forms were not

comprehensively completed to ensure that they were being used safely with residents. Some questions on assessment were left blank. When inspectors reviewed the practice of using bed rails they found that residents could not reach the call bell to seek assistance when the bed rails were in place. The risk management measure of checking bed rails two-hourly was not completed every night. The safety check of bedrails, as outlined in the assessment form, was not conducted on a regular basis.

Other assessments such as those for use of lap belts were contradictory in their findings and their guidance to staff.
For example, one assessment found that the resident was not at risk of slipping down the chair when using a lap belt and another assessment for the same resident stated that the lap-belt was in place to prevent the resident from slipping down the chair.

In addition, inspectors noted that physical restraint was being used to take blood samples from some residents. These incidents were documented in the nursing notes however, there was no assessment, protocol or consultation in relation to consent from the resident and/or family around this process. These incidences had not been notified to the Authority as required by Regulation 31.

A positive behavioural support service and behaviour risk assessment process was in place for residents who displayed challenging behaviour. However, staff explained to inspectors that they had not received training on how to complete the assessment documentation and could not explain how this measure helped to support residents' positive behaviours and quality of life. Inspectors found that the documentation was predominantly a risk assessment which documented the behaviour with little focus on identifying the antecedents or describing measures to alleviate the behaviour. Staff told inspectors that it was difficult to support residents in this regard due to a lack of staff. A minority of staff had received training in positive behavioural support and behaviours that challenge. This was an action on the last inspection. This lack of training was of significant concern as there were a number of residents with significant behaviours that challenge .

Instances of the use of chemical restraint were also evidenced on inspection which also had not been notified to the Authority. Medication administration sheets and daily record notes were cross referenced and inspectors found that PRN (as required) medications had been administered to residents during instances of inappropriate sexual behaviour, after residents absence without leave from the centre and when residents were 'elated'. The PRN (as required) protocols were conflicting in places and gave different accounts of when this medication could be used. There was a lack of evidence to indicate that staff were guided in the administration of PRN (as required) psychotropic medications.

The policy on behavioural support referred to a policy on restrictive practice, however this policy was not in place in the centre.

Due to above serious failings, an immediate action plan was requested from the provider in relation to safeguarding and safety. However, the action plan responses submitted by the provider to the Authority to ensure that appropriate safeguarding arrangements would be implemented to protect all residents from abuse were inadequate and rejected, and the provider was required to take further action.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
Overall inspectors found that the submission of notifications to the Authority regarding incidents of significant concern was wholly inadequate. During the inspection, evidence was found across all bungalows in the centre of serious incidents that had not been notified to the Authority as required by Regulation. Management in the centre had failed to meet this regulatory requirement.

Numerous incidents of allegations of abuse throughout 2014 and 2015 had not been notified to the Authority within three days of occurring. Evidence was found of several incidents of resident unexplained absence from the centre which occurred in 2014 and 2015 had also not been notified to the Authority within three days of occurring. Allegation of staff misconduct had not been notified to the Authority which was also concerning given that the information which triggered this inspection indicated that staff were alleged to have physically assaulted a resident.

The centre had not submitted a report to the Chief Inspector at the end of each quarter from 01/11/2013 to 31/12/2014 as required by Regulation 31(3).

Quarterly reports were received by the Authority for quarters 1 and 2 of 2015, however, not all incidents of resident injury (unexplained bruising) had been notified. In addition, from 01/11/2013 to 31/12/2014 numerous incidents of unexplained bruising, many of which had been recorded on incident forms and reported to management, had not been submitted to the Authority as either an allegation or suspicion of abuse or an incident of resident injury.

Inspectors also noted that the aforementioned use of physical restraint to take bloods from a resident and the use of chemical restraint for several residents had not been submitted on the quarterly notifications in 2015.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Residents were not being supported to achieve maximum independence in the centre. The statement of purpose outlined that 'on-going up-skilling and transitioning is encouraged and embraced'. However, as outlined under Outcome 5 Social Care Needs, residents' goals and wishes for development were not being supported, worked towards or evaluated on a regular basis. The residents were not facilitated to participate in education, training and development programmes.

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):
No actions were required from the previous inspection.

Findings:
Residents had access to medical care and evidence of regular medical review was seen. Evidence of resident referral and review by speech and language therapists and physiotherapists was also seen.

Inspectors reviewed a sample of personal care plans and noted that they did not adequately address the assessed healthcare needs of residents. For example, there was no care plan for supporting residents with a diagnosis of dementia, diabetes or who had a visual impairment. Residents with weight loss were not being monitored properly and recommendations for referral to health professionals were not being followed up. When inspectors spoke with staff, they were unable to describe the healthcare needs of the

residents adequately.

The use of clinical assessment tools in the centre was inconsistent. Falls risk assessments were not comprehensively completed for all residents. For example, the second part of the falls risk assessment tool to outline the interventions to mitigate the risk of falls was not completed in all cases.

Inspectors observed the preparation of meals and mealtimes in the centre. While mealtimes were generally social and interactive, poor practice was observed as regards food safety and hygiene in the preparation of residents' evening meal in one bungalow. A staff member was observed not adhering to hand hygiene after handling raw meat and continued to prepare other food and items in the kitchen.

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 reviewed the storage of medication trolleys and found that since the last inspection they were still being stored in the quiet room in some bungalows. This was an action on the last inspection; while the trolleys were locked however, this was not a suitably secure location to store residents' medication.

The signature sheet for all nurses administering medication on each bungalow was not up to date. Inspectors saw that on several days a nurse, whose signature had not been indicated on the signature sheet to identify each nurse involved in medication administration, had administered medication.

The recently conducted medication audit system in the centre did not identify that the nurse medication signature sheet was not up to date. Gaps were seen in the medication administration records as identified by the inspectors and as documented in the medication audit. However, the actions to address this issue were inadequate to provide assurance that this would not reoccur.

The medication policy did not include information to outline who has prescribing rights in the centre. The PRN (as required) protocol which inspectors saw was used in practice

to record the details regarding the administration of PRN (as required) medications was not referenced anywhere in the policy.

One resident's PRN (as required) protocol referred to the use of lorazepam, however this medication was no longer prescribed; therefore the protocol was not up to date.

Inspectors saw evidence that there were insufficient protocols for the administration of medications such as prescribed and PRN (as required) laxatives. When laxatives were administered on a PRN (as required) basis, the effect was not always documented in the daily notes. Inspectors were not assured that staff had the appropriate knowledge around the administration of these medications.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose did not comply with Schedule 1 of the Regulations and had not been updated since the last inspection when an action had been issued regarding this.

The statement of purpose was not centre specific as it made reference in several places to another designated centre on the same campus.
The statement of purpose did not adequately address the following:
- criteria for admission to the centre
- a description of the rooms in the centre, including their size
- any separate facilities for day care
- the total staffing complement
- the organisational structure of the centre
- the arrangements made for dealing with reviews of the residents' personal plans
- details of any specific therapeutic techniques used in the centre and arrangements made for their supervision
- the arrangements made for respecting the privacy and dignity of residents, especially residents sharing a twin bedroom
- arrangements for residents to access training and employment.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall, inspectors found that the governance systems and arrangements were wholly inadequate. The management structure in the centre was unclear. The person in charge, as notified to the Authority, was not the person in charge in practice. Members of management spoken to confirmed to inspectors that they did not have the capacity to manage effectively or to fulfil their role as required under Regulation. The day to day management processes were inadequate, as evidenced by a lack of reporting of incidents and a lack of response by management to on-going and serious risks in the centre. These risks included recorded resident on resident physical and alleged sexual assaults.

There was a lack of audits conducted in the centre. Incidents had been collated numerically in a tabular format for certain bungalows, however no actions or improvements were brought about or evidenced from the review of all of these incidents.

There was no annual review of the quality and safety of care and support in the centre. Unannounced visits, as required by Regulation 23 (2) to review the quality of care and support, had not been conducted.

Staff were not being facilitated to raise concerns with management and the quality and safety of care and support for residents. Staff, at various grades, informed inspectors that there was a lack of structured meetings between management and staff. Staff outlined that they had repeatedly raised issues verbally regarding staffing to managers but that nothing had changed to improve resident supervision and care in this regard. Issues regarding staff shortages which impacted negatively on resident activation had also been raised.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
The arrangements in place for the management of the centre when the person was absent were inadequate. All members of management spoken to by inspectors were clear that they did not have the capacity to fulfil the person in charge role for this centre as well as covering the other three centres in this campus.

Judgment:
Non Compliant - Major

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

Theme:
Use of Resources

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

Findings:
There were inadequate resources available in the centre. This was evidenced by a lack of staff on duty to meet the needs of the residents every day. Some staff who spoke with inspectors outlined that they were often responsible for five or six residents in a bungalow on their own if the other staff member rang in sick. There were occasions where extra staff support had been requested by staff and members of the medical team to provide one to one support for residents to protect their safety or to provide positive behavioural support. However, management had outlined that they were unable to fulfil these requests. Inspectors formed the view based on the observations during inspection and from speaking to staff and management that the lack of staff resources

impacted on residents as their assessed needs were often not met.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found that there were inadequate numbers of staff on duty. There were numerous occasions evidenced whereby the staff compliment in certain bungalows was not met, due to sickness or leave, and these staff were not replaced. In the locked bungalow with residents with behaviours that challenge, the number of staff on the duty roster was not sufficient to meet the assessed needs of residents. This lack of staffing often contributed to incidents of resident on resident physical assault, and resident absence without leave from this bungalow.

In addition, staffing in the centre was inconsistent and this impacted on the needs and quality of life of the residents. Agency staff were providing one to one care for certain residents. Inspectors were informed by staff that this inconsistency caused distress to particularly for residents with behaviours that challenge. Nursing staff in other bungalows also informed inspectors that they did not work consistently on any particular bungalow which again did not facilitate the development or implementation of residents' personal plans and meeting their individual needs.

Staff informed inspectors that management did not ensure that staff skills and knowledge were considered when assigning staff duties. Staff stated to inspectors that the seniority of staff was a deciding factor in the allocation of staff, rather than their experience, skills, suitability or capabilities.

The staff training files were reviewed and inspectors found that staff were not being provided with appropriate training to enable them to fulfil their roles. Not all staff had training in fire safety, protection of the vulnerable adults and communication needs. Most of the staff had no training in positive behavioural support in order to meet the needs of residents. The overall training programme was inadequate as practice in the

centre indicated that staff were unsure of what action to take in response to serious incidents that regularly occurred in the centre.

A sample of staff files were reviewed and the provider had not obtained all of the documentation required in Schedule 2 of the Regulations to indicate that staff were suitable to work in the centre. One staff file for a clinical nurse manager was not available in the centre. A full employment history was not in place for all staff and the details regarding the staff members position, the work performed and the hours employed were not in place for all staff.

Judgment:
Non Compliant - Major

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

Theme:
Use of Information

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

Findings:
There was no Directory of Residents available in the centre as required by Regulation 19.

Inspectors found that there wasn't a record of admission date or transfer details for all residents.

The provider had not ensured that policies in the centre were appropriate to the centre and were being implemented. The finance policy was reviewed and it not address the management of residents' personal property adequately, for example it did not outline that a second contemporaneous signature (where available) was required when transactions involving residents' finances were made.
The medication management policy was not adequate as it did not correspond with practice in the centre. The complaints policy was not up to date as the nominated complaints officer was no longer a member of staff.

There were a number of gaps in the documentation in place in staff files as required by

Schedule 2 of the Regulations.
Judgment: Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002463
Date of Inspection:	04 August 2015
Date of response:	30 September 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Screens were not in place around beds in the residents twin bedrooms which impacted on the privacy and dignity of residents.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

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:
Curtains will be fitted in the twin rooms which will enhance each individual's privacy and dignity.

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not facilitated to participate in regular activities to meet their needs, interests and capacities.

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:
Each resident will be facilitated to complete a likes / dislikes questionnaire. The information gathered will be used to facilitate their participation in activities that they enjoy and that will meet their needs.

Proposed Timescale: 31/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate evidence of action in response to all complaints and it was not recorded whether or not the complainant was satisfied with the outcome of the complaints process.

3. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The complaints form has been reviewed to ensure that action has been taken in response to all complaints. The process of handling a complaint will be reinforced to each staff member and the importance of recording the resident's satisfaction with the outcome and response to the complaint will be highlighted to all staff.

Proposed Timescale: 31/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints process states that the "Director of Nursing/Deputy" will receive and acknowledge all complaints. However, this person is not named and their contact information is not provided for residents, relatives or visitors.

4. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
The complaints posters, leaflets and policy will be reviewed and updated to ensure that the designated complaints officer is named and that contact details are available.

Proposed Timescale: 31/10/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not assisted or supported to communicate as the communication assessments were inadequate, there were no communication interventions set out in their personal plans and staff had no training in communication.

5. Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
• The recruitment of a speech & language therapist with the necessary skills to work in this area has taken some time. A therapist has now been recruited on a part-time basis to assess each resident's communication skills where appropriate.
• Visual schedules will be created for use on the units to detail daily events, staff on duty and meal choices.
• It will take a number of months for this therapist to undertake comprehensive and appropriate assessments. This will include observation of each resident in their environment, assessment of each resident's verbal and non-verbal communication skills and completion of communication checklists by staff and family members in respect of

each resident.
• In the interim Communication Training for all staff will commence in October/November 2015 and additional courses are being planned for January 2016. The emphasis of this training will be on non verbal communication strategies, use of visual cues and an introduction to the PECS (Picture Exchange Communication System) method of communication.
• This training will facilitate staff to support residents' communication while awaiting a full SLT assessment.

Proposed Timescale: 31/01/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of communication aids, equipment or assistive technologies to support residents communication needs or promote their full capabilities.

6. Action Required:
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:
• A Speech and Language Therapist has been recruited on a part-time basis and will be engaged to assess residents' communication needs and provide advice and training to staff in relation to this area.
• Residents will be facilitated to access SLT as appropriate immediately. However, it will take a number of months for the therapist to undertake comprehensive assessments and where necessary trial augmentative systems including PECS, communication charts, assistive technology etc. A period of intervention by the SLT will then be required to support residents to use these systems effectively.

Proposed Timescale: 31/01/2016

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there was contact with families, those families were not being informed about major events and incidents being experienced by residents. Most residents were not supported to develop or maintain links with their local community.

7. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to

develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
Engagement and contact with family members will be recorded and documented as appropriate in all residents' files.

Each resident will be facilitated to complete a likes / dislikes questionnaire. The information gathered will be used to facilitate their participation in activities that they enjoy and that will meet their needs.

Proposed Timescale: 31/10/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contracts for service were not sufficient and did not demonstrate that the provider had agreed in writing the service to be provided to the resident.

8. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
All contracts of care will be reviewed and reissued to resident / relative / next of kin as appropriate. All contracts will be signed by a witness to the agreement.
The revised contracts will be signed by the provider nominee.

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fees for additional charges to residents were not outlined in the contracts.

9. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

Contracts of care will be reviewed and reissued to resident / relative / next of kin as appropriate. The revised contracts will include information regarding fees for additional services, where appropriate/required.

Proposed Timescale: 30/11/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to put in place arrangements to ensure that the social care needs of residents were being met, as assessed and set out in their personal plans.

10. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
A process of comprehensively reviewing each resident's personal plan has commenced to ensure that their social care needs are identified.
Action plans will be developed and appropriate supports will be put in place to address their individual needs.

Proposed Timescale: 31/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents had a personal plan completed in the centre.

11. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the 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:
A person-centred plan will be completed for all residents.

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
There was no evidence to indicate that effectiveness of residents' person centred plans were being reviewed.

12. 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:
• A process of comprehensively reviewing each resident's personal plan will be put in place to ensure the effectiveness of each personal plan.
• This review will occur regularly to ensure that the plan evolves to reflect changes in the residents' wishes and needs.

Proposed Timescale: 31/12/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There continued to be deficits in the premises arrangements since the previous inspection and some parts of the centre were not homely but were clinical in nature.

13. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
• Curtains will be fitted in the twin rooms which will enhance each individual's privacy and dignity.

• Individual hand wash basins will be installed in the double bedrooms.

• Guidelines are in place in relation to the sluice room. These have been developed in conjunction with Infection Prevention and Control Nurse for the safe movement and disposal of dirty waste.

• Medication trolleys have been moved from the quiet room and are stored securely in a dedicated area.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have suitable arrangements for the safe disposal of clinical waste as there was only one sluice room located in the locked bungalow in the centre.

14. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
Infection control and prevention guidelines are in place for management of all soiled waste which ensures the safe disposal of clinical waste. These have been agreed in consultation with the HSE Infection Control Nurse.

Proposed Timescale: 30/09/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate systems in place to learn from accidents and incidents in the centre in order to improve resident safety and inform staff.

15. 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:
• The PIC will meet with the CNM for this centre and other relevant staff on a weekly basis. The agenda for this meeting will include a review of all operational issues, including incidents, complaints or any other significant issues that occurred in the previous week. Safeguarding will also be a standard item on this agenda.
• The PIC/ADON will have at least daily face-to-face contact with the CNM in the centre to discuss operational issues including any incidents, staffing issues or complaints that have occurred.
• Incident Record book is reviewed by the PIC on a weekly basis and the PIC provides a report on same to the ADON on a monthly basis. The PIC clarifies with the CNM on a daily basis as to whether or not there are any incidents or serious reportable events that need to be reported to HIQA or elsewhere as appropriate.
• The PICs for all of the designated centres in this area will meet with the Acting DON weekly. (The Acting DON is currently PIC for 2 centres. This will change when a further CNM3 is recruited.) The CMN3 rosters will be reviewed to facilitate this weekly meeting. This group will meet with the CNS on a weekly basis. The agenda for this meeting will also include a review of incidents, safeguarding, staffing and other

operational issues that may arise.
• The registered provider will attend these meetings monthly. This meeting will include a review of all serious reportable events and HIQA notifications.
• Regular audits of incidents will be undertaken by the CNS (Positive Behaviour Support Manager) in consultation with the PIC.
• Risk register will also be reviewed during meetings.
• Anything highlighted as a red risk will be flagged to senior HSE management.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedures around sluicing in the centre were inadequate and posed a risk of infection and cross contamination to residents.

16. 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:
Infection control and prevention guidelines are in place for management of all soiled waste which ensures the safe disposal of clinical waste. These have been agreed in consultation with the HSE Infection Control Nurse.

Proposed Timescale: 30/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were not held regularly in the centre.

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

Please state the actions you have taken or are planning to take:
• Fire drills to be completed every 6 months.
• Fire drills/evacuation took place in this centre on 7th May/23rd June/26th June 2015
• A further fire drill / evacuation will take place by 31st October 2015.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Several fire doors were held open by fire wedges, which impacted on the effectiveness of the fire arrangements in the centre..

18. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
• The use of door wedges to hold open fire doors has ceased.
• Staff education regarding the hazards of using unauthorized door wedges has been completed. An information leaflet has been developed and been circulated.

Proposed Timescale: 04/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date fire safety training.

19. 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:
• Fire drills are completed at least every 6 months.
• Fire safety training will be provided for all staff members and training log will be updated accordingly.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Part of providers fire precautions included daily checks of fire exits. This was not being implemented.

20. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
• Daily fire checks to be fully completed.
• The CNM2 will ensure through weekly checks that the daily fire check sheet is completed.

Proposed Timescale: 16/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was using personal emergency evacuation plans as part of the evacuation plans for the centre and these were inadequate to support staff and residents in the event of a fire.

21. 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 emergency evacuation plans have been completed and in place for all residents

Proposed Timescale: 01/09/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have the necessary knowledge and skills to manage behaviours that challenge to support residents.

22. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
• A process of staff training in supporting residents who present with behaviours of concern will be facilitated.
• PMAV Trainers will visit the service on Saturday 26/09/2015 to assess training needs with regards to implementing a programme of training to address this deficit.

• In the interim the CNS (Positive Behaviour Support Specialist) will continue to work with staff in all units to facilitate the identification of triggers and techniques for de-escalation.

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Most staff did not have training in behaviours that challenge.

23. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
• A process of staff training in supporting residents who present with behaviours of concern will be facilitated.
• PMAV Trainers will visit the service on Saturday 26/09/2015 to assess training needs with regards to implementing a programme of training to address this deficit.
• De-escalation and interventions skills will form part of the PMAV training which will be delivered to all staff over the coming months.
• In the interim the CNS (Positive Behaviour Support Specialist) will continue to work with staff in all units to facilitate the identification of triggers and techniques for de-escalation.

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the positive behaviour support plans and the implementation of these plans was supporting residents with behaviours that challenge in alleviating the behaviours.

24. 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:
As part of the process of comprehensively reviewing each resident's personal plan, their individual positive behaviour support plans will be evaluated for effectiveness and issues

highlighted will be addressed through updating actions in each plan.

Clinical nurse specialist nurse is in place for the service to support staff in implementing the programmes and will be consulted for input when updating the personal plans.

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of physical (bed rails and lap belts) and chemical restraint in the centre was not managed in line with national policy and evidence based practice.

25. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
• A review of all bedrails and lap belts will be completed by person in charge in conjunction with newly appointed occupational therapist to ensure compliance with national policy.

• The use of chemical restraint is monitored on a weekly basis by the person in charge and CNM2.

Proposed Timescale: 31/10/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not adequately protected from abuse in the centre.

26. 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:
Safeguarding plans have been developed for each service user and will be reviewed every 3 months or sooner if required with the issues and / or concerns identified being addressed in a timely manner.

The PIC will meet with the CNM for this centre and other relevant staff on a weekly basis. The agenda for this meeting will include a review of all operational issues, including incidents, complaints or any other significant issues that occurred in the previous week. Safeguarding will be a standard item on this agenda.

The PIC/ADON will have at least daily face-to-face contact with the CNM in the centre to discuss operational issues including any incidents and safeguarding issues.

The PICs for all of the designated centres in this area will meet with the Acting DON weekly. The CMN3 rosters will be reviewed to facilitate this weekly meeting. This group will meet with the CNS on a weekly basis. The agenda for this meeting will also include a review of incidents and safeguarding issues.
The registered provider will attend these meetings monthly. This meeting will include a review of all serious reportable events and HIQA notifications.
Regular audits of incidents including peer on peer abuse will be undertaken by the CNS (Positive Behaviour Support Manager) in consultation with the PIC

Proposed Timescale: 01/09/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Incidents of abuse were not adequately investigated in the centre and safeguarding actions did not protect the residents in the centre.

27. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
All incidents of alleged abuse will be investigated in line with local and national safeguarding vulnerable adult policies.

Safeguarding plans in place will protect residents in the centre.

Proposed Timescale: 01/09/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to training in the protection of vulnerable adults. Staff and management knowledge of the protection of vulnerable adults was inadequate.

28. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
All staff will receive training in the protection of vulnerable adults

Proposed Timescale: 30/11/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Incidents of resident unexplained absence from the centre had not been notified to the Authority.

29. Action Required:
Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

Please state the actions you have taken or are planning to take:
All incidents of unexplained absences from the designated centre will be notified to the authority as per regulations.

Proposed Timescale: 16/09/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Allegations or suspicions of abuse, including unexplained bruising, which were found on inspection had not been notified to the Authority.

30. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
All incidents of allegations or suspicions of abuse, including unexplained bruising, will be notified to the authority as per regulations.

Proposed Timescale: 16/09/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
Allegations of staff misconduct had not been notified to the Authority

31. Action Required:
Under Regulation 31 (1) (g) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation of misconduct by the registered provider or by staff.

Please state the actions you have taken or are planning to take:
All incidents of staff misconduct will continue to be notified to the authority as per regulations.

Proposed Timescale: 16/09/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A quarterly report of the use of restraint had not been submitted to the Authority from 01/11/2013 to 31/12/2014.

32. Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
The use of restraint will be notified to the authority as per regulations at the end of each quarter.

Proposed Timescale: 30/09/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Incidents of resident injury were not reported to the Authority every quarter from 01/11/2013 to 31/12/2014. When quarterly reports were received for quarters 1 and 2 2015, not all incidents of resident injury (unexplained bruising) had been notified.

33. Action Required:
Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

Please state the actions you have taken or are planning to take:
All incidents of injury to a resident will be notified to the authority as per regulations at

the end of each quarter.

Proposed Timescale: 30/09/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not facilitated or supported to participate in education, training and development programmes to support their independence.

34. Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
• A process of comprehensively reviewing each resident's personal plan will ensure their needs are identified.
• Action plans will be developed and put in place to address their individual needs, with particular focus on their participation in education, training and development programmes, where appropriate.

Proposed Timescale: 31/01/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate healthcare was not being provided to residents with a diagnosis of dementia, weight loss or diabetes or those with visual impairment to meet their needs in this regard. There was no healthcare plan in place for a resident with non-insulin dependent diabetes.

35. 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:
• A process of comprehensively reviewing each resident's personal plan will ensure their needs are identified. This will include the identification of residents with diabetes who require a healthcare plan and residents who require a MUST screening tool score.
• Action plans will be developed and put in place to address their individual needs; including updating of healthcare plans and completion of MUST screening tool for

residents who require this.
• The residents identified above will be prioritised. All other reviews will be scheduled based on the identified priority of the resident.

Proposed Timescale: 30/11/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were inadequate food preparation processes observed on inspection to maintain food safety.

36. Action Required:
Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

Please state the actions you have taken or are planning to take:
Briefings in relation to food preparation processes will be provided for staff involved in food preparation for residents.
As there is a comprehensive programme of training currently under way in this centre the release of staff to attend this briefing will be scheduled as soon as possible.

Proposed Timescale: 31/12/2015

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:
The inspectors were not assured that PRN (as required) medications were administered as prescribed, in line with evidence based practice.

Not all prescriptions had the resident's photograph attached.

There were gaps in the medication administration sheets identified by inspectors and by the medication audits.

37. 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:
Audit of prescription and administration of medication by person in charge to be

completed monthly and identified issues to be addressed. This will include:
1. Ensuring bowel management plan in place for residents who require this;
2. Ensuring photographs are attached to each prescription;
3. Although medication sheets are being completed by staff members, discussions will be held with staff to ensure that these are completed in full.

Proposed Timescale: 30/09/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication trolleys were not being stored appropriately.

38. Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
Medication trolleys have been moved from the quiet room and are now stored securely in a dedicated area.

Proposed Timescale: 01/09/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not meet the requirements of Schedule 1 of the Regulations and had not been updated since the last inspection.

39. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Statement of Purpose will be reviewed by person in charge to ensure it meets the requirements of Schedule 1 of the regulations and will be updated, as required.

Proposed Timescale: 31/10/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge arrangements were inadequate as the nominated person in charge was not acting in this capacity.

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

Please state the actions you have taken or are planning to take:
A Person in Charge at CNM3 level has been appointed for the centre. Relevant paperwork will be submitted to HIQA.

The Person in Charge will be based as far as possible on site in the unit.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure in the centre was not clearly defined.

41. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
• An outline of the management structure will be documented in the statement of purpose.
• A PIC at CNM3 level has been appointed for this centre. The PIC is supported by nursing staff, including CNM2, CNM1 and staff nurses; agency specials, care assistants and housekeeping staff. The PIC receives support and input from the CNS in Positive Behaviour Support. The PIC reports directly to the Director of Nursing for the centre. The DON reports to the Provider Nominee, who in turn reports to the Chief Officer.
• Discussions have taken place with staff at CNM2 and CNM1 level to highlight the need for day to day operational issues to be addressed at that level. This will allow the CNM3 to focus on the PIC responsibilities.
• As this structure is consolidated it will facilitate the separation of the designated centres in the area into distinct units. The appointment of additional staff at CNM3 level will support this.

• Team meetings are held between all staff members at unit level. The PIC and CNM will have daily face-to-face contact to discuss any operational issues/incidents that have occurred. A weekly unit management meeting is held between the PIC and the CNM2. A weekly Managers' meeting is held with the Director of Nursing and PICs for each of the units in the centre. A Management Governance Group meeting is held monthly which comprises the Provider Nominee, Director of Nursing, Administrator and Persons in Charge for all units in the centre.
• Items discussed at these meetings include, and are not limited to, safeguarding of residents, review of Serious Reportable Events, HIQA notifications, risk management and Quality Improvement.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structures were inadequate to ensure the safety of care, and monitoring of same, in the centre.

42. 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:
• A PIC at CNM3 level has been appointed for this centre. The PIC is supported by nursing staff, including CNM2, CNM1 and staff nurses; agency specials, care assistants and housekeeping staff. The PIC receives support and input from the CNS in Positive Behaviour Support. The PIC reports directly to the Director of Nursing for the centre. The DON reports to the Provider Nominee, who in turn reports to the Chief Officer.
• Discussions have taken place with staff at CNM2 and CNM1 level to highlight the need for day to day operational issues to be addressed at that level. This will allow the CNM3 to focus on the PIC responsibilities.
• As this structure is consolidated it will facilitate the separation of the designated centres in the area into distinct units. The appointment of additional staff at CNM3 level will support this.
• Team meetings are held between all staff members at unit level. The PIC and CNM will have daily face-to-face contact to discuss any operational issues/incidents that have occurred. A weekly unit management meeting is held between the PIC and the CNM2. A weekly Managers' meeting is held with the Director of Nursing and PICs for each of the units in the centre. A Management Governance Group meeting is held monthly which comprises the Provider Nominee, Director of Nursing, Administrator and Persons in Charge for all units in the centre.
• Items discussed at these meetings include, and are not limited to, safeguarding of residents, review of Serious Reportable Events, HIQA notifications, risk management and Quality Improvement.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review of the quality and safety of care in the centre had not been conducted.

43. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
Completed by external consultant in July and August 2015. Report completed on 17/08/2015.

Proposed Timescale: 17/08/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no unannounced visit to the centre to monitor the safety and quality of care provided to residents.

44. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
Provider Nominee will conduct an unannounced visit every 6 months.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were not facilitated to raise concerns about the quality and safety of care.

45. Action Required:

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

Please state the actions you have taken or are planning to take:
Weekly meeting are held with the person in charge, CNM2 and CNM1 for the area. The standing agenda is safeguarding issues, incidents / near misses, welfare and safety of residents.
The responsibilities of all staff to raise concerns about the quality and safety of residents and the process of reporting any concerns has been reinforced to all staff.

Proposed Timescale: 01/09/2015

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements in place for the management of the centre when the person was absent were inadequate. All members of management spoken to by inspectors were clear that they did not have the capacity to fulfil the person in charge role for this centre as well as covering the other three centres in this campus.

46. Action Required:
Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.

Please state the actions you have taken or are planning to take:
• A Person in Charge has been appointed for the centre. Relevant paperwork is to be submitted to HIQA.
• The identification of two additional PICs for other centres in the area will facilitate a system of cross cover.
• Discussions have taken place with staff at CNM2 and CNM1 level to highlight the need for day to day operational issues to be addressed at that level. This will allow the CNM3 to focus on the PIC responsibilities.
• As this structure is consolidated it will facilitate the separation of the designated centres in the area into distinct units. The appointment of additional staff at CNM3 level will support this.
• The structure of regular meetings at unit level will facilitate the mentoring & development of staff at CNM2 level so that over time they will be able to cover for the PIC.

Proposed Timescale: 30/09/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have adequate staff on duty, or extra staff put in place when required, to ensure that the needs of the residents were being met.

47. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
• A comprehensive recruitment plan for 34 additional staff members across all units in the centre has been implemented in order to ensure the safe continuation of services to all residents.
• Once recruitment has been completed, there will be an additional two staff members rostered to this unit during the daytime shift and an additional two staff members for the night-time shifts.
• In total, 13 Health Care Attendants have been appointed to the service in recent months. 12 additional Social Care Workers were recruited and began working with the service on 31st August 2015. The recruitment of 12 additional Registered Nurses in Intellectual Disability is on-going.
• From 14th September 2015 staff rosters will be managed at unit level.
• Staffing levels have been increased within the centre. Two residents have an identified 1:1 resource by day and by night since September 2015 which enables the full implementation of their safeguarding plans.

For the residents who reside in this specific centre, the current complement of staff is:
• PIC at CNM3 level.
• A CNM2 Monday to Friday.
• 15 staff members consisting of care assistants and nurses with an additional 3 housekeeping staff during daytime.
• 10 staff members consisting of care assistants and nurses with an additional 1 housekeeping staff member at night-time.

Proposed Timescale: 31/12/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient numbers of staff on duty to meet the needs of the residents.

48. 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:
• A comprehensive recruitment plan for 34 additional staff members across all units in the centre has been implemented in order to ensure the safe continuation of services to all residents.
• Once recruitment has been completed, there will be an additional two staff members rostered to this unit during the daytime shift and an additional two staff members for the night-time shifts.
• In total, 13 Health Care Attendants have been appointed to the service in recent months. 12 additional Social Care Workers were recruited and began working with the service on 31st August 2015. The recruitment of 12 additional Registered Nurses in Intellectual Disability is on-going.
• From 14th September 2015 staff rosters will be managed at unit level.
• Staffing levels have been increased within the centre. Two residents have an identified 1:1 resource by day and by night since September 2015 which enables the full implementation of their safeguarding plans.

For the residents who reside in this specific centre, the complement of staff is:
• PIC at CNM3 level.
• A CNM2 Monday to Friday.
• 15 staff members consisting of care assistants and nurses with an additional 3 housekeeping staff during daytime.
• 10 staff members consisting of care assistants and nurses with an additional 1 housekeeping staff member at night-time.

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all information required in Schedule 2 of the Regulations had been obtained for all members of staff.

49. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
All information will be available for staff in compliance with schedule 2.

Proposed Timescale: 30/11/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inconsistency of staffing arrangements which caused distress to residents and impacted on the development and implementation of their personal plans.

50. 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:
From 14th September 2015 staff rosters will be managed at unit level.
As appropriate, staff will be rostered to specific areas to promote continuity of care.

Proposed Timescale: 14/09/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The overall training programme in the centre was inadequate and did not enable staff to meet the needs of the residents.

51. 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:
The process of staff recruitment is on-going. The recruitment of additional staff will facilitate the release of staff to attend training as required.
A process of comprehensively reviewing each resident's personal plan will ensure their needs are identified. Action plans will be developed and put in place to address their individual needs.

Proposed Timescale: 31/01/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Several policies did not reflect practice in the centre.

52. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement

all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Directory of residents in place.

Proposed Timescale: 01/09/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A directory of residents was not available in the centre.

53. Action Required:
Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

Please state the actions you have taken or are planning to take:
Directory of residents in place.

Proposed Timescale: 01/09/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The requirements of Schedule 2 were not in place in all staff files.

54. Action Required:
Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
All information will be available for staff in compliance with schedule 2.

Proposed Timescale: 30/11/2015

Theme: Use of Information

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

The effect of PRN (as required) medication was not documented for each occasion of administration.
There were gaps in the nurse signature sheets and in the administration records of medication administration sheets.
Not all incidents in the centre were being documented on incident forms.
Details of residents' communication needs were not adequate.

55. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
• Audit of prescription and administration of medication by person in charge to be completed monthly and identified issues to be addressed. This will include ensuring that nurse signature sheets and medication administration sheets are fully completed.

• Compliance by all staff with the centre's Incident Reporting Policy has been reinforced to all staff.

• Recruitment of an occupational therapist and speech and language therapist has been completed and, in conjunction with the person in charge, these therapists will provide details of the residents' communication needs and provide information regarding the residents' receptive and expressive language capabilities, where applicable.

Proposed Timescale: 31/01/2016