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 The Cheshire Foundation in Ireland
Centre ID:	OSV-0003440
Centre county:	Donegal
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Lorraine Egan
Support inspector(s):	Jude O'Neill on Day 1
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 April 2016 09:30	12 April 2016 17:30
13 April 2016 09:10	13 April 2016 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

HIQA undertook a series of inspections of centres operated by Cheshire Foundation Ireland during 2015 and found a high level of non-compliances with the requirements of the regulations and the National Standards. In particular, inspectors found that the provider did not have adequate governance arrangements to ensure a safe and good quality of service for residents. The provider was required to attend a meeting with HIQA on 25 November 2015 and at that meeting, the provider told inspectors of a plan to reconfigure governance arrangements, improve support for local managers and address the areas of non compliance in each centre.

Since that meeting HIQA has seen evidence that the provider is implementing their actions to improve the services. However, HIQA remained concerned of the level of non-compliance in some centres. The provider was required to attend a meeting in HIQA on 14 April 2016 where concerns regarding services including this centre were discussed with the provider. In response to HIQA's concerns, the provider advised of impending changes to the governance and management structures and reporting procedures across the service that would positively impact on the quality and safety

of care provided to residents and address all outstanding concerns.

Inspectors will continue to monitor compliance in designated centres to ensure that any improvements required are implemented and that the changes proposed by the provider are addressing the identified non-compliances.

Background to the inspection
This inspection was carried out to monitor compliance with specific outcomes. The previous inspection of this centre took place on 9 February 2015. As part of this inspection, inspectors reviewed the actions the provider had undertaken since the previous inspection. Of the six actions required, two had been addressed in line with the provider's response and three had not been addressed and remained non-compliant on this inspection. While one action had been addressed, the findings on this inspection indicated that the provider was still non-compliant with the relevant regulation.

How we gathered our evidence
As part of the inspection, inspectors met with seven residents. Residents told inspectors they were happy in the centre and liked the person in charge and the majority of staff working there. Some residents said they would like to go out more and have more control over their lives.

Inspectors also spoke with staff members and the person in charge of the centre. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. An interview was carried out with the person in charge.

Description of the service
The provider must produce a document called the statement of purpose that explains the service they provide. Inspectors found that while some aspects of the service were being provided as it was described in that document, not all aspects were being provided as described. This included access to activities, the management of complaints and facilitating residents to take responsibility for their own care and personal affairs if they so wish.

The centre is purpose built to provide 12 accessible apartments. There is also communal space in the building for residents. The service is available to adult men and women who have physical and neurological disabilities.

Overall judgment of our findings
Overall, inspectors found residents' healthcare needs were being met and the provider had implemented appropriate systems to ensure the centre could be evacuated safely in the event of a fire or other emergency.

However, inspectors were not satisfied that the provider had put systems in place to ensure that all regulations were being met. The governance systems in the centre were not ensuring the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

This resulted in poor experiences for residents, the details of which are described in the report.

Good practice was identified in areas such as:
· Residents' healthcare needs were being met
· The premises was designed and laid out to meet the needs of the residents

The inspectors found that the lack of effective governance and management systems had resulted in:
· Some residents were not supported to participate in, and consent to, decisions about their care and support (Outcome 1)
· Complaints were not always responded to appropriately and residents were not supported to access advocacy services which resulted in residents' rights not being prioritised (Outcome 1)
· There was a lack of opportunity for all residents to access activities (Outcome 1)
· Some fees charged were not transparent (Outcome 4)
· Residents' social care needs were not consistently assessed, arrangements were not in place to meet all assessed needs and the effectiveness of personal plans had not been assessed (Outcome 5)
· Some residents did not have healthcare plans for all assessed needs, some healthcare plans were not adequately specific and some plans were not reviewed annually (Outcome 5)
· A risk related to accessing the centre had not been identified and responded to (Outcome 7)
· Residents were not adequately protected against the risk of abuse and an allegation of abuse had not been investigated in a timely manner (Outcome 8)
· Efforts to identify and alleviate the cause of behaviours that challenge and ensure residents were supported to develop the skills for self protection were not effective (Outcome 8)
· Some practices relating to the administration of medicines were not adequately robust and residents had not been supported to take responsibility for their own medicines (Outcome 12)
· Staffing levels and skill-mix had not been assessed, staff training needs had not been assessed and some required training had not been provided, the staff rota was not clear, staff files did not contain all items required and supervision and performance management of staff had the potential to negatively impact on the care and support provided to residents (Outcome 17)

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors did not inspect all aspects of this outcome.

Inspectors observed friendly and respectful interaction between residents and staff. Residents spoken with said they were treated well and some residents said they would tell the person in charge if they were not treated with respect. However, an inspector reviewed questionnaires which had been completed by residents and found that some residents had raised concerns regarding the way they were treated by some members of staff. The comments made included 'sometimes the staff are crabit with me', 'most of the staff treat me good but one or two don't' and a resident ticked the box for 'not very well' to the question asking how they were treated by staff. The findings in these questionnaires had not been responded to at the time of the inspection.

In addition, an inspector reviewed a sample of multidisciplinary meetings which took place to discuss each resident's care and support. It was not documented that residents were in attendance at these meetings and there was no rationale as to why residents were not invited and facilitated to attend. It was therefore not evident that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participated in and consented, with supports where necessary, to decisions about his or her care and support.

Provision of intimate care
An inspector reviewed a sample of residents' intimate care plans. Some care plans provided adequate guidelines outlining residents' preferences in regard to the provision of their personal and intimate care. However, a resident did not have a care plan

outlining their preference in the provision of intimate care. It was therefore not evident that care and support was being provided in line with the resident's wishes.

Complaints
A record of complaints received was maintained in the centre. Residents spoken with said they would make a complaint and some residents gave examples of complaints they made and said they were resolved to their satisfaction. However, the records maintained did not include the outcome of the complaint and a record of whether or not the complainant was satisfied. In addition, it was not evident that complainants had been made aware of the appeals process.

The response to some complaints was not adequate. For example, a number of complaints were made by a resident about the same issue. The complaint had not been resolved to the resident's satisfaction and it was not evident the resident's rights had been prioritised. The resident had not been supported to access advocacy services to assist them in resolving these complaints to their satisfaction.

Access to activities
An inspector reviewed questionnaires completed by residents and found that residents had raised concerns regarding the lack of access to activities. Comments made included '...go to the park instead of shopping all the time', 'to get out a bit more' and 'bored' all of the time. Inspectors observed some residents alone in their apartments for long periods of the day. There was no assessment of residents' preferences and wishes in regard to activities and it was therefore not evident that this was consistent with residents' needs and wishes.

Judgment:
Non Compliant - Moderate

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:
Inspectors did not inspect all aspects of this outcome.

A sample of residents' agreements for the provision of services were reviewed by an inspector. The agreements did not include the detail of all fees payable by the resident. In addition, the payment of household bills was not transparent. Some residents were

paying different utility bills and varying amounts. It was not evident that the payment of utility bills was based on the use of the utility by the resident.

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
A comprehensive assessment, by an appropriate health care professional, of the social care needs of each resident was not carried out. There were limited opportunities for residents to identify goals relating to social care.

Arrangements had not been put in place to meet the assessed needs of each resident. For example, a resident had not received support to meet their needs in regard to accessing opportunities for employment.

The healthcare plans were not specific in regard to some aspects of support required by residents and some assessed needs did not have a corresponding care plan in place. For example, manual handling care plans did not specify the hoist and sling required by the resident and residents assessed as a high risk of developing pressure sores did not have a care plan in place outlining the measures taken to mitigate or reduce this risk.

Some residents' healthcare plans were not reviewed annually. Some plans had not been reviewed since December 2014. It was therefore not evident that all information was up-to-date and relevant to the current care required by the resident.

Information in residents' personal plans was not reviewed to assess the effectiveness of the plans. This had been identified at the previous inspection of this centre and had not been addressed.

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):
No actions were required from the previous inspection.

Findings:
Inspectors did not inspect all aspects of this outcome.

The centre comprised of a single storey building located close to a town centre. Each resident had an individual apartment with a living room/kitchen, bedroom and accessible bathroom. The majority of apartments visited by inspectors were furnished by the resident and reflected the resident's personality and preferences. Some residents told inspectors they had chosen the decor. However, it was not evident the decor of one apartment was based on the resident's wishes.

There was a communal sitting room for residents' use. Inspectors observed a resident using this room on the evening of the inspection. Some improvement was required to the decor as, although it was comfortable and homely, the room contained the CCTV (closed circuit television) screens for the centre and the charging station for the centre's many phones.

There were two conservatories which, inspectors were told, were used by residents and visitors. The decor of these rooms required updating. In addition, the rooms were used to store items which could not be stored in residents' bedrooms due to lack of available space. Storage facilities in the centre needed to be identified to ensure these rooms were used in line with their purpose.

Inspectors found the centre was easily accessible. The doors were adequately wide to accommodate wheelchair users and automatic doors were in place at the entrance to the centre.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
There were systems in place to promote and protect the health and safety of residents, respite users, visitors and staff. Improvement was required to the measures to ensure residents' private apartments were not easily accessible to members of the public.

Risk Management
There was a risk register which set out the risks in the centre and the associated control measures. The risk management policy identified the procedures for the identification and management of risk in the centre.

There were individual risk assessments which outlined the risks particular to each individual resident and respite user and the measures in place to control the risks.

A risk in regard to access to the centre had not been identified and responded to. Inspectors noted a room in the centre was utilised by external persons and groups. The centre was easily accessible and there was no differentiation between the communal areas of the centre and residents' private apartment areas.

There were arrangements in place for investigating and learning from accidents and incidents. An inspector read a number of accident and incident records. Incidents were reported, the corrective action was documented and all records were maintained.

Fire Safety
An inspector reviewed the maintenance and servicing records for the fire alarm, emergency lighting and fire equipment and found that they had been serviced appropriately.

Fire doors with cold smoke seals were in place throughout the centre. Daily checks on aspects of fire safety took place in the centre.

There was an emergency plan which guided staff regarding the evacuation of the centre in the event of a fire or other emergency. Floor plans which identified the fire zones and compartmentalisation were in place throughout the centre.

Individual personal evacuation plans outlined the support residents and respite users required in the event an evacuation of the centre was necessary. A sample of these were viewed and provided adequate guidance for staff in regard to supporting residents and respite users to evacuate the centre if necessary.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
Allegations of abuse of residents had been notified to HIQA. An investigation was taking place and an inspector was informed the findings would be submitted to HIQA in due course. Staff spoken with were knowledgeable of the procedure to follow if they received an allegation of abuse and residents said they would raise any concerns with the person in charge of the centre or a staff member.

However, an allegation of intimidation of a resident by a staff member had been made and there was no evidence the allegation had been investigated. In addition, this allegation of psychological abuse had not been report to HIQA and it was not evident it had been recognised, responded to or investigated in line with the centre's procedures and the national safeguarding policy.

The person in charge told an inspector that this had been brought to the attention of the persons nominated to carry out an unannounced inspection of the centre for the provider in February 2016. The person in charge said they were informed this was being investigated by a person working for the organisation and not working in the centre.

At the feedback meeting held at the end of the inspection, the lead inspector requested an update of this investigation from a senior person participating in the management of the centre. This manager told the inspector that a preliminary investigation had been carried out and the inspector would be emailed a copy of the investigation. Following the inspection the inspector received a copy of the investigation. However, the information contained in the preliminary investigation did not assure the inspector that the allegation had been identified and responded to in a timely manner to ensure that the resident and all residents were protected from the risk of psychological abuse.

Restrictive practices
A medicine, which was prescribed to manage a resident's behaviour, was prescribed to be administered p.r.n. (a medicine only taken as the need arises). However, the prescription sheet was unclear due to the illegibility of the handwriting. There were no guidelines for staff in administering this medicine and no outline of measures which should be tried prior to administration. It was therefore not evident that every effort to identify and alleviate the cause of residents' behaviour was made; that all alternative measures were considered before a restrictive procedure was used; and that the least restrictive procedure, for the shortest duration necessary, was used.

Residents' finances
The person in charge outlined the measures for supporting residents to manage their finances. A new system had been introduced and each resident had documentation pertaining to their wishes. Some residents were supported by family members while others were supported by the person in charge and staff. However, it was not evident that all residents were supported in line with their wishes. For example, a resident had clearly stated that they were not happy with the arrangements in place. In addition, these arrangements were impinging on the resident spending their money in line with their wishes. Further, it was therefore not evident that all residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection in relation to their finances.

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 and respite users received support to attend preventative healthcare, including attending consultants and undergoing examinations, to ensure all healthcare needs were identified and responded to in an appropriate timeframe. Residents and respite users were supported to access their general practitioner (GP), dentist and allied health professionals such as speech and language therapists, occupational therapists and physiotherapists as required.

Food was available in adequate quantities and residents and respite users were supported to prepare meals in their apartments. Respite users who required assistance with modified diets received appropriate support.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
An inspector reviewed the procedures in place for the management of medicines in the centre and found they were safe. Residents' medicines were stored in their apartments and residents were supported by staff in the administration and review of medicines.

An inspector viewed a sample of prescription sheets and found they contained all required information with the exception of the specific prescribed time for some medicines to be administered. However, some aspects of the management of medicines required improvement. It was not evident that residents had been supported to take control of their own medicines if they so wished. There was no evidence of risk assessments or assessments of capacity in regard to residents self administrating medicines.

The guidelines for administrating a medicine which was prescribed to be administered in a specific medical emergency were not adequately robust. The prescription sheet did not contain the maximum dose and the protocol did not state the procedure to be followed if the medicine was not effective. Furthermore, the information contained in the care plan relating to this medical condition did not state that this medicine was prescribed.

Some medicines were administered as crushed. A letter stating the medicines were to be crushed was signed by a different medical professional than the general practitioner. The prescription sheet did not identify these medicines as suitable for crushing.

The provider's response to the previous report stated that all staff would receive training in administering medicines to residents. An inspector found that this had not been addressed. The person in charge attributed this to staff reluctance to complete this training. However, it was not evident that appropriate measures had been taken by the provider to ensure staff participated in all required training.

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:
There was a written statement of purpose which set out a statement of the aims, objectives and ethos of the designated centre. It also stated the facilities and services which are to be provided for residents.

The statement of purpose did not contain all information required. It did not contain the whole time equivalent staffing of the staff nurse and senior care worker posts; the size of all rooms in the centre; and the post of deputy CEO was not included in the organizational structure.

In addition, the separate facilities for day care were not clearly identified and the development and review of residents' personal plans referred to healthcare plans only.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
As outlined in outcomes 1, 4, 5, 7, 8, 12 and 17 the management systems in the centre were not ensuring the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The provider had carried out an unannounced visit to the centre in February 2016 and had prepared a report on the findings. Significant areas of concern were identified as part of this visit. Although the provider had addressed some areas and had notified HIQA of some findings, inspectors found the provider had not implemented a satisfactory plan to address all non-compliances identified.

Inspectors found a number of non-compliances had not been addressed. For example, access to activities, residents' contracts, meeting residents' social care needs and recognising and responding to allegations of abuse had been identified as areas of significant non-compliance and had not been addressed. As outlined in outcomes 1, 5 and 8, inspectors found non-compliance in relation to these matters.

The failure of the provider to implement effective governance systems was resulting in poor outcomes for residents and had the potential to further negatively impact residents' lives.

There were inadequate systems in place to ensure the centre was governed effectively in the absence of the person in charge. There was no person identified to provide governance when the person in charge was on unplanned leave.

The report of the unannounced visit by the provider had identified urgency in notifying HIQA of two persons participating in management of the centre. However, a notification had not been submitted for one person and a fully completed notification had not been submitted for the other person.

The necessity to ensure there was a management presence in the centre outside of the person in charge's core working hours had not been addressed. The person in charge told an inspector it was her understanding that the two persons hired in management roles would be working evenings and weekends. However, she said these persons were not working out-of-hours and this had not been addressed.

There was an on call system to provide out-of-hours support for the centre and staff in the evenings, at night and at weekends. This was shared between managers working in the region. The person in charge told the inspector she was also available by phone in the evenings and at weekends.

The arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering were not adequately effective. An inspector was told that some training had not been provided as staff had declined to attend or complete training.

The provider had not ensured an annual review of the quality and safety of care had taken place. This was identified on the previous inspection of the centre and had not been addressed.

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):
No actions were required from the previous inspection.

Findings:
It was not evident that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre.

The person in charge outlined the decreased staffing levels in the centre which resulted in staffing levels not being maintained on all days. Interviews were taking place on the first day of the inspection and the person in charge said the suitable candidates would commence in the centre as soon as practicable.

It was not evident the staffing levels were based on the assessed needs of residents. An assessment of the required staffing levels had not taken place since 2008. The person in charge told an inspector that she was undertaking a review of the staffing levels using a tool which had been amended to provide specific information for the needs of residents living in the centre.

It was not evident the hours of nursing care and support provided was meeting the needs of residents. The person in charge told an inspector this had been identified and the inspector viewed documentation which showed that this had been brought to the attention of a senior manager.

Staff Rota
An actual and planned staff rota was maintained in the centre. However, the actual rota was not reflective of the staff members working in the centre. The rota included staff who were not working in the centre due to leave. It was therefore difficult to ascertain the staffing levels and specific staff on duty in the centre on each day.

Staff Training
A training needs analysis for the centre and for staff members had not been completed. The training required for staff working in the centre had not been assessed to ensure that all training was provided.

An inspector reviewed the staff training records and found that some staff had not received training in safeguarding residents and the prevention, detection and response to suspected or confirmed allegations of abuse; fire prevention, fire control techniques and the use of first aid fire fighting equipment; manual handling; the management of behaviour that is challenging including de-escalation and intervention techniques and the safe administration of medication. In addition, staff members providing assistance and support for residents in preparing meals and supporting residents with dysphagia had not received training in food hygiene and dysphagia.

Staff Files
A review of staff files had been carried out by a person employed by the provider to complete an audit. On reviewing a sample of staff files, an inspector noted that the audit was not reflective of the inspector's findings. Some items not included in the staff files had not been identified in the audit. Some staff files did not include the staff member's full employment history, two references, a reference for the staff member's most recent employer and evidence of the person's relevant qualifications.

Staff supervision
The centre had attempted to introduce a formal support and supervision mechanism for staff. However, the commencement of this system was delayed due to issues with staff members' union representation which had yet to be resolved. The person in charge told an inspector she expected this to be resolved in a short period of time.

The failure of some staff to undertake required training and fully complete training had been identified. However, it was not evident that this was being addressed by the provider to ensure all staff had received required training.

It was therefore evident that the lack of formal supervision for staff and effective performance management systems had the potential to impact negatively on the care and support provided to residents.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003440
Date of Inspection:	12 April 2016
Date of response:	29 June 2016

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:
It was not evident that each resident's privacy and dignity was respected in relation to intimate and personal care as not all residents had intimate care plans in place.

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

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 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:
One resident did not have an intimate care plan in place. This is now in place since 18th April 16. An intimate care is now in place for all residents.

Proposed Timescale: 18/04/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participated in and consented, with supports where necessary, to decisions about his or her care and support.

2. Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
A) The Person in Charge will meet each resident on a Monthly basis with regard to the quality of their service and their views on their supports. These meetings will be recorded and any necessary actions will be followed up by the appropriate person.
B) All residents and their family members/representatives where appropriate will be invited to participate in Multi-Disciplinary Reviews of their care. Where it is not possible for people to attend review meetings, their views will be sought and documented to feed into the process.
C) The Care plan in relation to one individual has been updated to include their preferences in relation to intimate care. (18th April 16)

Proposed Timescale: 01/07/2016 and ongoing

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Opportunities to participate in activities in accordance with residents' interests, capacities and developmental needs were not provided for all residents.

3. 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:
A) An assessment and social care plan will be developed for each resident which details their interests and goals and how these may be met. Progress on these plans will be documented on a quarterly basis.
B) The Provider will open discussions with the Funder as to how additional/different supports could be provided to ensure that residents have increased opportunities for development and to participate in activities of their choosing.
C) All activities which residents participate in will be recorded in their care plan to ensure oversight of the frequency of access to activities and outings and that they are in accordance with their interests and development needs.

Proposed Timescale: 31/08/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that residents had access to advocacy services for the purposes of making a complaint.

4. Action Required:
Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

Please state the actions you have taken or are planning to take:
A) All residents/family members will continue to be informed at each individual and residents meeting about the availability of advocacy and the confidential recipient.
B) Posters giving contact details on the Advocacy service have been displayed throughout the centre.
C) A resident complaint in relation to access to IT equipment has been reviewed. The resident was provided with IT equipment of their choice on 16/04/2016
D) A complaint in relation to access to his finance has also been reviewed. Access to advocacy services has been arranged for the resident on 24th June 2016.

Proposed Timescale: 24/06/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that all complainants were informed promptly of the outcome of their complaints and details of the appeals process.

5. Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
a) All complainants will be informed of the outcome of their complaint in writing as soon as the complaint process has been completed.
b) An Appeals process is displayed in the centre. All residents will be informed of the appeals process in a one to one meeting with the PIC, through written information in easy to read format and at resident's meetings.
c) Complaints will be reviewed on a monthly basis by the Regional Manager and any necessary follow up actioned with the Person in Charge.

Proposed Timescale: 01/07/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The record of complaints did not include detail of the outcome of all complaints and whether or not the resident was satisfied.

6. 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:
A) A record of the outcome of all complaints will be maintained in the centre's complaints file, attached to the original complaint.
B) A satisfaction questionnaire will be made available to the complainant or their representative detailing their satisfaction or otherwise with the resolution.

Proposed Timescale: 01/07/2016

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:
Some residents' agreements for the provision of services did not include the fees to be charged and some fees charged were not transparent.

7. 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:
A) All service agreements will be reviewed to include fees payable by each resident in respect of rent and Electricity bills.
B) This will be made available in different formats suitable to the needs of residents

Proposed Timescale: 01/07/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements had not been put in place to meet the assessed needs of each resident.

8. 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) Social Care needs will be tracked and reviewed for progress on a quarterly basis.
B) Where assessed needs have been identified, goals and support required will be identified through care plans and progress tracked on meeting these needs until completion.

Proposed Timescale: 31/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment, by an appropriate health care professional, of the social care needs of each resident was not carried out.

9. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
A social care assessment will be carried out by a suitably qualified individual and a plan will be developed for each resident which details their interests and goals and how these may be met. Progress on these plans will be reviewed and documented on a quarterly basis and changes made as required.

Proposed Timescale: 31/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents' personal plans were not reviewed annually.

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

Please state the actions you have taken or are planning to take:
All personal plans have now been reviewed within the last year and will be reviewed annually or more often as required.

Proposed Timescale: 24/06/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A personal plan had not been put in place for all residents' assessed needs.

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) Care plans are in place for all residents. A full audit of all care plans has been completed on 21st July 2016 and identified gaps are being addressed by staff members in consultation with residents.
b) Each care plan will be reviewed on a three monthly basis or as required when an assessed need changes. i.e. hospital admission and return home, change in medication, change in social support need.

Proposed Timescale: 09/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not evident that personal plan reviews assessed the effectiveness of each plan and took into account changes in circumstances and new developments.

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) All plans will be subject to an annual review and all changes will be recorded.
B) Reviews will take place more regularly where there is a change of circumstances.
C) All service users and their representatives where appropriate will be invited to participate in Multi-Disciplinary Reviews. Family members will be spoken to in advance of MDT reviews to both invite them, update them and consult with them about decisions, with consent from the residents. This will ensure effectiveness of the current plan and identify required changes.

Proposed Timescale: 24/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that a resident's apartment was suitably decorated in line with their wishes.

13. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
The PIC has been in consultation with a resident about their choice for the redecoration of their apartment. Once their wishes have been confirmed the apartment will be redecorated.

Proposed Timescale: 08/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The decor of some aspects of the centre required improvement, for example the communal sitting room and the conservatories.

14. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
The conservatories and living room are being redecorated after consultation with residents.

Proposed Timescale: 08/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some storage facilities in the centre were not suitable.

15. 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:
All items have been removed from the conservatory to a proper storage area.

Proposed Timescale: 12/04/2016

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 was no system in place in the designated centre for the assessment, management and ongoing review of a specific risk in the centre.

16. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
A) The provider has implemented a new Risk Management system within the centre designed to identify, record, and communicate risks in terms of their comparative importance.
B) Its key function is to provide local Management, the Provider, and key stakeholders with significant information on the main risks faced by the division and the relevant policies and systems in place to negate/reduce these risks to a suitable level.
C) Signage has been placed in the centre to demarcate private accommodation areas from communal areas. CCTV monitors have been relocated to the reception office to ensure staff have easier access and to remove it from the residents living area.
A list of all users of the activity room is maintained to ensure accountability of all visitors. A visitor's book is maintained in the centre in the reception area.

Proposed Timescale: 24/06/2016

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:
It was not evident that every effort to identify and alleviate the cause of residents' behaviour was made; that all alternative measures were considered before a restrictive procedure was used; and that the least restrictive procedure, for the shortest duration necessary, was used.

17. 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:
A) Arrangements, which could be described as restrictive are currently in place for two residents. Both cases have been referred to advocacy services as of 28th June 2016.
B) A review of an arrangement in relation to Finance for one resident will be held, and will involve an independent advocate, the service user, family members. A referral has been made to the independent advocate on 28th June 2016.
C) The PRN medication included in the report was a temporary prescription and is no longer in place. Any future use of PRN medicines will include legible handwriting, and a protocol in place for staff detailing which alternative measures should be taken prior to administration. This will ensure that any future use of PRN medication is for the shortest duration and used only when all other measures have been employed.

Proposed Timescale: 15/08/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident was not assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection in relation to their finances.

18. Action Required:
Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Please state the actions you have taken or are planning to take:
A) A review of the arrangement in relation to Finance will be held involving an independent advocate, the service user, family members and the Provider's Quality Officer. A referral has been made to the independent advocate on 28th June 2016.
B) The resident's wishes in relation to managing his money will be reviewed with him/her and these will be detailed in the money management plan. The resident's wishes, as agreed with them during the review of their money management plan, will be adhered to in regard to the management of his/her money. The resident will be supported by an advocate during the money management review.

Proposed Timescale: 15/08/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of intimidation of a resident by a staff member was not investigated in a timely manner.

19. 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:
A) All allegations of abuse or inappropriate behaviour will be dealt with in a timely manner according to Cheshire Ireland's Adult protection framework and Investigation procedures
B) A management review will be carried into the allegation of intimidation referred to in order to promote learning.
C) A Preliminary Screening into an allegation of intimidation will be completed in a timely fashion as soon as the staff member allegedly involved returns to work.

Proposed Timescale: 31/08/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Findings raised concern that residents were not protected from all forms of abuse.

20. 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:
A) The Provider has restructured the staffing arrangements in the Western Region to include a Regional Quality Partner who will visit the centre on at least a six weekly basis and is available to provide support and advice. (Completed 31/03/16)
B) A National Safeguarding Officer is now in place with responsibility to provide support guidance and oversight on safeguarding issues (completed 31/03/16
C) Adult Protection training has been held with local staff and management. (completed 22/04/16)
D) Safeguarding Awareness training is being rolled out across the Providers centres for care staff.
E) The PIC will undertake Designated Officer training with the HSE.
F) Adult Safeguarding will be a fixed agenda item on all resident's meeting and staff meetings.
G) The National Safeguarding lead is developing an awareness session on Adult Safeguarding for all residents. This will be held in Donegal by 31st August 2016:
H) An unannounced Quality and Safety audit will be carried out bi- annually by the Provider and will detail any actions needed on safeguarding residents.
I) All complaints received will be reviewed by the Provider on a monthly basis and followed up with the PIC.

Proposed Timescale: 31/08/2016

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:
There was no evidence residents were encouraged to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

21. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
A Self Administration assessment will be completed with all residents to ascertain their wishes on supports needed if any to manage medication. Follow up actions will be put in place following completion of these assessments by the PIC with support from the Clinical Partner.

Proposed Timescale: 08/07/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some practices relating to the 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 were not robust.

22. 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:
A) Since May 2016 a new medication management policy and standard operating procedure has been implemented. Within this there are robust audit tools conducted monthly to ensure clinical oversight of the administration of medication
B) In addition Bi Annual audits are undertaken by the Regional Clinical partner to ensure further governance
C) The medication policy will be raised at each staff meeting
D) All staff is being retrained in Medication Management. This process commenced on 25th May 2016 and will be completed by 31st October 2016. (Some staff is currently on extended absences.

Proposed Timescale: 31/10/2016

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 contain all 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.

23. 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:
The Statement of Purpose will be amended to include the information set out in schedule 1 of the Health Act regulations.

Proposed Timescale: 01/07/2016

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:
Management systems were not ensuring that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

24. 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) Recruitment is underway for a Staff Nurse and Senior Care Worker who will both be designated as PPIM's.
B) Weekly meetings are held between the Regional Manager and the PIC either in person or by Zoom call. These are documented. Any concerns arising at these meetings are highlighted to the Head of Operations.
C) A Weekly Monitoring report will be submitted by the PIC to the Regional Manager and Head of Operations. This report will be based on the actions required in the HIQA action plan.
D) The Provider's Head of Operations will conduct a management investigation into the operations of the centre. Terms of Reference have been forwarded to the inspector and will include a section on relationships within the centre and training and support given and required. The findings from this investigation will be used to decide course of action necessary to ensure the appropriate local governance and supervision of all staff working in the centre.
E) Two persons who were being designated PPIM have left the service. Once recruitment has completed for a new PPIM, relevant documentation will be completed and forwarded to the Authority by the Provider.

Proposed Timescale: 31/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The plan in place to address concerns regarding the standard of care and support provided in the centre was not adequate.

25. 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:
A) The Provider's Head of Operations will conduct a management investigation into the operations of the centre. Terms of Reference for the investigation have been forwarded to the inspector and will include a section on relationships within the centre and training and support given and required. The findings from this investigation will be used to decide on the course of action necessary to ensure the appropriate local governance and supervision of all staff working in the centre.
B) The Head of Operations will conduct a monthly visit to the centre.
C) A weekly monitoring report will be sent to both the Regional Manager and the Head of Operations by the PIC. This report will be based on the actions required in the HIQA action plan.
D) A performance improvement plan for the PIC will be designed and agreed between the Regional Manager and Head of Operations .This will be put in place by 3rd August 2016. This will be reviewed monthly over a four month period with HR. Following the four month review any further actions will be reviewed and agreed.

Proposed Timescale: 08/08/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering were not adequately effective.

26. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
A) The Provider's Head of Operations will conduct a management investigation into the operations of the centre. Terms of Reference for the investigation will include a section on relationships within the centre and training and support given and required. The findings from this investigation will be used to decide on the course of action necessary to ensure the appropriate local governance and supervision of all staff working in the centre.
B) The PIC will be supported by the Regional Manager to hold a staff meeting to discuss the findings of this report and to work with staff to ensure that they are aware of their roles and responsibilities including the HIQA judgement framework.
C) Monthly staff meetings are held and will be continued. A structured agenda and minutes will operate
D) One to one meetings will be held with all staff on a six weekly basis. This discussion will include training and development needs, service issues and workplace support.

Proposed Timescale: 09/09/2016

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 and support in the designated centre had not taken place.

27. 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:
An Annual Review is taking place and a report will be available on 1st July 2016.

Proposed Timescale: 01/07/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

28. 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) Recruitment has been carried and 4 new care staff have been employed in May 2016
B) Another 5 care staff has been recruited and will start as soon as the relevant documentation required under schedule 2 has been received.
C) An in depth care needs assessment is being carried out by the Provider nationwide in July/August 2016 and the centre will be part of this process. This analysis will be completed by 31st August 2016 will include details of the staffing requirement including numbers skill mix, qualifications and experience required.

Proposed Timescale: 31/08/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The actual staff rota did not clearly show staff on duty at any time during the day and night.

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

Please state the actions you have taken or are planning to take:
Two rosters are now maintained in the centre to ensure clarity. A master rota and a working rota are available.

Proposed Timescale: 19/04/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The information and documents as specified in Schedule 2 had not been obtained for all staff.

30. 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:
Staff files will be audited to ensure they contain the required information as specified in schedule 2.

Proposed Timescale: 15/07/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have access to required training and there was no assessment of the training needs for staff working in the centre.

31. 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:
A) A learning needs analysis is carried out locally and nationally which includes 3 steps
1) Mandatory statutory training is included on the Learning Needs analysis for all centres. (For example Moving and Handling, Fire Safety)
2) The Provider's Heads of function decide on national organisational training needs on an annual basis in consultation with Senior Management and this is also included in the Learning Needs Analysis.
3) An analysis will be undertaken by the PIC for the needs of the designated centre, including mandatory and locally specific training. This will be completed by 5th August 2016
B) All training identified in the Analysis will be resourced and delivered.
C) Safeguarding Training will be provided for all staff who have not yet undertaken it.
D) Some staff members are currently on paid absences. On return they will be assessed with regard to training needs and training will be provided.

Proposed Timescale: 31/08/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The lack of formal supervision for staff and effective performance management systems had the potential to impact negatively on the care and support provided to residents.

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

Please state the actions you have taken or are planning to take:
A) The PIC will be supported by the Regional Manager to hold a staff meeting to discuss the findings of the HIQA report and to work with staff to ensure that they are aware of their roles and responsibilities including the need to meet the requirements of the HIQA judgement framework.
B) Monthly staff meetings are held and will be continued. A structured agenda and minutes will operate.
C) One to one meetings will be held between the PIC and all staff on a six weekly basis.

These meetings will include training and development needs and service issues. D) The Provider's Head of Operations will conduct a management investigation into the operations of the centre. Terms of Reference for the investigation have been forwarded to the inspector and will include a section on relationships within the centre and training and support given and required. The findings from this investigation will be used to decide on the course of action necessary to ensure the appropriate oversight and supervision of all staff working in the centre.
Proposed Timescale: 09/09/2016