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:	O'Dwyer Cheshire Home
Centre ID:	OSV-0003452
Centre county:	Mayo
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Colin McIlrath
Lead inspector:	Lorraine Egan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	2

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:
16 August 2016 10:20	16 August 2016 18:50
17 August 2016 09:30	17 August 2016 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 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

HIQA undertook a series of inspections of centres operated by Cheshire Foundation Ireland during 2015 and found 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 found evidence that the provider was implementing their actions to improve the services. However, HIQA remained concerned at the level of non-compliance in some centres. The provider was required to attend a further 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 monitoring inspection was carried out to assess if the provider had addressed the actions as outlined in the response to the action plan of the inspection which took place on 26 January 2016. In each outcome, the inspector focused on the actions taken by the provider to achieve compliance with the failings identified during the previous inspection.

How we gathered our evidence:
As part of the inspection, the inspector met with three residents. The inspector was available to meet with all residents. One resident declined to speak with the inspector and one resident was not in the centre on the days of inspection. Two respite users were going home from the centre on the morning of the first day of the inspection and the inspector met with one respite user as they were leaving.

Residents and the respite user spoken with told the inspector they were happy in the centre and liked staff working there. Residents told the inspector the centre was their home and they would not like to live anywhere else. Residents spoke positively of the structural changes to the centre.

The inspector also spoke with staff members, the person in charge of the centre and persons participating in the management of the centre. The inspector observed practices and reviewed documentation such as residents' support plans, medical records, accident logs, policies and procedures and staff files.

Description of the service:
The provider must produce a document called the statement of purpose that explains the service they provide. In the areas inspected, the inspector found that many aspects of the service were provided as described in that document. However, improvements were required in some areas.

The centre was located in a rural area and was a ten minute drive from the nearest towns. The centre had three vehicles for residents and respite users to use and some residents had purchased their own vehicles.

Since the previous inspection the centre had been reconfigured and was a smaller and more homely centre. All residents had individual apartments with a living room/dining room/kitchen, an accessible bathroom and one or two bedrooms. Residents had moved to the newly configured centre on 22 July 2016.

Respite users had individual bedrooms with en-suite bathroom facilities and shared kitchen, dining and living space when staying in the centre. The centre met residents' assessed needs in regard to the physical premises.

The service was available to adult men and women who have physical and neurological disabilities.

Overall judgment of our findings:
The inspector was not satisfied that the provider had put systems in place to ensure that the actions required from the previous inspection were addressed and ensure the centre was in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (hereafter referred to as the regulations).

Of the 32 actions which were identified at the previous inspection, 12 had been addressed in line with the provider's response. Although the provider had implemented some measures to address the 20 remaining actions these measures either had not been sustained or had not ensured the centre was compliant with the relevant regulation. In addition, the inspector found the provider was non-compliant with a further five regulations on this inspection.

The provider's failure to address actions from the previous inspection had impacted negatively on the quality of life of residents living in the centre. For example, residents were not protected by safe medicine management practices; staff had failed to report residents' concerns of poor care practices; there was insufficient support for residents to access activities; the provider had failed to respond to residents' complaints; and residents were not consulted with.

The person in charge was required to take two immediate actions on the days of inspection. One related to access to the centre and the other related to a concern raised by a resident relating to care practices. The findings and the immediate responses are outlined in Outcomes 7 and 8.

In addition, further improvements were required in the following areas:
- Residents' Rights, Dignity and Consultation (Outcome 1)
- Access to internet (in Outcome 2)
- Support for residents to access to the community (in Outcome 3)
- A resident's contracts (in Outcome 4)
- Provision of residents' plans in an accessible format (in Outcome 5)
- Aspects of fire safety (in Outcome 7)
- Notification of incidents (Outcome 9)
- Access to opportunities for education, training and employment for all residents (in Outcome 10)
- Medication Management (Outcome 12)

- Statement of Purpose (Outcome 13)
- Governance and Management (Outcome 14)
- Use of Resources (Outcome 16)
- Workforce (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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Residents had been supported to understand their rights and a charter of rights had been developed. The inspector was told this was on display in the old part of the centre prior to residents moving to the new part of the centre. The person in charge said it would be placed on the wall in the new part of the centre.

Residents' rights had been discussed with residents and residents had been supported to vote in line with their wishes. However, the inspector found that a resident had not been supported to meet with their solicitor. The inspector was therefore not assured that all residents were supported to exercise their legal rights.

Systems to ensure residents were consulted and supported to participate in the organization of the centre had been implemented. However, these systems had not been sustained. For example, monthly resident meetings and monthly one-to-one meetings were identified as the method of consulting with residents in the provider's response to the previous inspection report action plan. However, the inspector found these meetings had not taken place since May 2016.

As outlined in the previous inspection report residents had requested activities take place in the centre and staff support them to access activities external to the centre. There were no activities provided in the centre and on reviewing access to external activities the inspector found limited support provided. This is discussed further in outcome 3 as it also relates to accessing the wider community.

The management of complaints in the centre required significant improvement. The provider had implemented a system to ensure complainants were informed promptly of the outcome of their complaints and details of the appeals process. The inspector found measures had been implemented in response to the finding of complaints.

However, the inspector found three complaints which had been made by residents in June 2016 had not been responded to. In addition, the person responsible for ensuring all complaints were responded to and records maintained had not carried out a review of complaints since April 2016 and a copy of the complaints procedure was not displayed in the centre.

Judgment:
Non Compliant - Moderate

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

Findings:
The provider had purchased a laptop to ensure residents could access the internet. The inspector was told this was used when residents lived in the old part of the centre.

However, wireless internet was not yet available in the new part of the centre and therefore the internet could not be accessed by residents. A resident had expressed interest in developing their computer skills which included accessing the internet. A staff member said they had an internet device which the resident could use in one part of the new building. However, this was dependent on the staff member being on duty.

Judgment:
Non Compliant - Moderate

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

Findings:
The hours allocated to 'community connector' staff had increased to 25 hours per week and 'social support' plans for residents had been formulated. However, the inspector found that some residents did not have adequate support to develop and maintain personal relationships and links with the wider community.

The inspector reviewed a sample of residents' 'social support' plans and found that while some residents were supported to develop and maintain personal relationships and links with the wider community this was not in place for all residents. Some residents told the inspector they were supported to access local shops and amenities when they wished. However, other residents said they were not supported when they wished and it was dependent on staff and transport availability.

A sample of records showed that residents had been supported to access the community between 17 and 26 times in a 5 month period. In addition, the documentation showed that residents' access to the community had decreased on a monthly basis since the commencement of the documentation in March 2016.

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

Findings:
Residents had new tenancy agreements and service agreements. In addition, the provider had implemented an easy read version encompassing the information in both agreements.

The inspector viewed a sample of these and found that the service provided and fees charged were clearly stated on all documents. However, of the sample viewed one resident's tenancy and service agreement differed in the fee charged.

Judgment:
Substantially Compliant

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:
Residents' personal plans had been reviewed and were signed by residents or, with the residents' consent, their representative. Residents had access to their personal plans.

However, the inspector found that the personal plans were not made available in an accessible format for all residents. This was discussed with the person with responsibility for overseeing these who said that a pictorial format would be formulated for residents who required this.

Judgment:
Substantially Compliant

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

Findings:
As outlined in the previous inspection report the original centre was a large 30 bedded centre when first constructed in the 1970's and was partially used at the time of the previous inspection.

The construction and refurbishment of part of the centre which was taking place at the time of the previous inspection had now been completed. The inspector noted further work was required, for example removal of hoarding, and was informed that the building company would be removing this in the coming week.

The centre comprised of five apartments for residents and two single ensuite bedrooms for respite users. In addition, there was a communal kitchen/sitting/dining room which was used by respite users and was available for residents use. Other rooms included offices, a staff sleepover room and bathroom, a toilet for visitors and storage rooms.

Residents had moved to the new part of the centre on 22 July 2016. Residents spoken with said they liked the new building and said that it was more accessible due to the smaller size.

The inspector found the centre was laid out to meet the aims and objectives of the centre and the needs of residents and respite users.

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

Findings:
The provider had implemented some improvements since the previous inspection of the centre. However, further improvements were required to the management of risk and fire safety in the centre.

Thermostatic control valves had been fitted in the centre to ensure residents and respite users were protected against the risk of scalding.

A new risk management system was in the process of being implemented in the centre. The inspector viewed the risk assessments and found that while these were in place some were not reflective of risks in the centre, for example some assessments related to

working with machinery.

A risk relating to access to the centre had not been identified, assessed or control measures implemented. The inspector outlined the risk related to this to the person in charge who was required to take immediate action in relation to this. The person in charge outlined the control measure which would be implemented. The inspector noted that if this was implemented it would mitigate the associated risk.

Although a plan had been put in place to ensure all respite users had taken part in a fire drill this had not been implemented. In addition, there was no record to show that all staff had participated in a fire drill. The inspector viewed fire drill records and found there was no fire drill in the centre from January 2016 to June 2016.

Two night time fire drills had taken place in July 2016. The fire drill records stated that three members of staff took part in these drills on each night. However, two staff were based in the centre at night with one staff providing support throughout the county. The person in charge acknowledged that the third member of staff may not be immediately available to evacuate the centre should an emergency evacuation be necessary. The person in charge outlined the intention to carry out unannounced fire drills at night to address this and ensure the centre can be safely evacuated with a complement of two staff at night.

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:
The systems to ensure residents were protected against all forms of abuse had improved however, further improvement was required. An allegation of abuse had been investigated and measures were implemented to ensure residents were protected. In addition, the inspector noted a safeguarding plan had been implemented to ensure a resident was protected from a specific risk of abuse.

All residents' apartment doors were accessed via a fob system and a door had been fixed to ensure a resident was safe in their apartment. Residents had received information about safeguarding and safety. Residents spoken with said they felt safe in the centre and would speak with staff if they had any concerns.

The inspector was not assured that residents were safeguarded from all potential forms of abuse. The inspector found that an alleged poor practice relating to an alleged injury sustained by a resident had not been investigated. The information relating to this was relayed to the inspector by a resident and was contained in the resident's daily care notes. However, this was not noted in the centre's incident book and the person in charge was not aware of this.

The person in charge was required to take immediate action. Prior to the end of the inspection the person in charge outlined the measures taken which included commencing a preliminary investigation. The inspector was told that the person in charge and their line manager considered this an allegation of abuse and would be investigating it in line with the centre and national policy and would notify HIQA of this.

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

Findings:
The inspector reviewed the record of accidents and incidents which had taken place in the centre. All documented incidents which required notifying to HIQA had been notified.

As outlined in outcome 8 an incident had not been identified as an allegation of abuse by the receiving staff members and therefore had not been reported to the person in charge. This was notified to HIQA two days after the inspection.

Judgment:
Compliant

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

Findings:
An assessment of residents' wishes in regard to education, training and employment needs had taken place for four residents. The inspector viewed these and found that residents' wishes were being supported.

There was no assessment of one resident's wishes in regard to education, training and employment. Staff spoken with, including the person in charge and those participating in management of the centre, did not provide an explanation for this.

The inspector was told the assessments had been carried out by a person who was no longer working in the centre. It was therefore not evident that there was effective oversight of this to ensure that all residents received equal opportunities in regard to the assessment of, and support to access, opportunities for education, training and employment.

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

Findings:
The inspector reviewed a sample of residents' healthcare plans. Annual reviews were carried out by a registered nurse and a system of annual multidisciplinary meetings had been implemented since the previous inspection of the centre. The meetings included an overview of each resident's care and support in regard to all aspects of healthcare.

In the sample of plans reviewed the inspector found that all assessed needs had corresponding care plans in place which outlined the care required. These were reviewed on a regular basis by a nurse.

The inspector viewed a sample of plans which outlined each resident's wishes for their end of life care. These outlined the resident's wishes in regard to their care and support at end of life, for example religious, legal and burial wishes were outlined.

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:
A review of medicine errors in the centre found that the systems in place to ensure adequate oversight and response to errors and the system in place for ensuring errors were identified and responded to in a timely manner were not adequate.

Documentation outlining medicine errors, for example those outlining omitting medicines, did not detail that timely action was taken for all errors and there was no documented follow up to one error relating to the omission of a medicine to a resident. In addition, it was not evident that the centre's procedure was followed in regard to these errors.

The inspector noted that the person in charge was reviewing medicine errors despite not having read the centre's procedure. The person in charge was not aware of the system outlined in the updated procedure for responding to medicine errors. It was therefore not evident that all errors had been responded to in line with the centre's procedure.

Staff who had received training were responsible for administering medicines. However, the system to ensure that all medicines were administered when staffing changes were made at short notice was not adequate. For example, some medicines had not been administered to residents as there was no person present in the centre with the required training. In addition, staff who had not received training did not bring this to the attention of management and therefore this was not identified in a timely manner.

Furthermore, although an error of omission of medicines to residents had been identified by the previous person in charge, and staff were formally contacted in writing, there was no outcome to this.

There was no system for ensuring that medicines were counted when respite users arrived in the centre and left the centre. Therefore, where errors were identified there was no way of ascertaining if the error related to an omission of the administration of medicines or an omission in signing the medicines as administered. In addition, there was no evidence that all reasonable attempts were made to ascertain whether or not medicines were omitted.

It was not evident that staff were aware of their duty of care to residents in relation to identifying and responding to errors and potential errors made by colleagues. Errors relating to medicines which were not signed as administered had not been responded to or brought to the attention of management in a timely manner.

As a result of these findings the inspector was not assured that there were appropriate management systems in place to ensure that medicines which were prescribed were administered as prescribed to residents.

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 set out a statement of the aims, objectives and ethos of the designated centre. It also outlined the services which were to be provided for residents and respite users.

However, the statement of purpose did not include a description of the rooms in the centre including their size and primary function. In addition, some amendments were required to the statement of purpose to ensure all information was clear and consistent. For example:
- the organization structure was not accurate
- the description of the facilities was not reflective of the refurbished centre

- the number of residents was inaccurate on the front page of the document
- the whole time equivalent (wte) of the person in charge, nurses, coordinators and community connectors were not reflective of findings on inspection
- the arrangements for dealing with residents' personal plans referenced healthcare plans only
- the description of fire precautions did not include all systems in place in the centre.

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:
Findings on this inspection raised concern that the governance and management of the centre was ineffective. The inspector found that the measures implemented by the provider to govern the centre in the absence of a full-time person in charge had not ensured that all aspects of the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The inspector found that the governance arrangements were not adequate to ensure consistent and effective oversight of the care and support provided to residents living in the centre. As outlined in outcome 12 the inspector was concerned that the systems in place for responding to, reviewing and mitigating the risk of reoccurrence of incidents were not effective and that the lack of oversight was placing residents at risk.

There was an ineffective system for ensuring that the provider implemented and sustained actions to address non-compliances identified on inspections. Although it was evident that some actions were addressed, the inspector consistently found that actions were not addressed or sustained in line with the provider's response to the previous inspection action plan. This included the support for residents to access activities, responding to residents' complaints, consulting with residents and supporting residents' to access the internet. The failure to implement required improvements, sustain progress and ensure effective oversight in the centre raised concerns that the

governance systems were not adequately effective.

A new person had been appointed to the role of person in charge three weeks prior to the inspection. The inspector found this person did not have adequate time to become accustomed to the role, their responsibilities and their regulatory responsibilities.

There were ineffective 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 were delivering. Some staff were not fulfilling their duty of care to residents, for example by failing to ensure residents were protected by safe medicine management practices and failing to report residents' concerns of poor care practices.

The provider, or a person nominated by the provider, had not carried out an unannounced visit to the designated centre at least once every six months as required by the regulations. At the feedback meeting held at the end of the inspection the senior person participating in management stated it was the organization's understanding that an unannounced visit was required 'twice a year'. The inspector clarified this with the persons present as specified by Regulation 23 (2) (a).

The service provider did not provide evidence that the designated centre complied with the Planning and Development Acts 2000-2013 and any building bye-laws that may be in force as required by the regulations. This document was required as part of the application to register the centre.

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

Findings:
It was not adequately clear if the finding on the previous inspection had been addressed. The inspector noted adequate staff was available to support residents throughout the inspection and provide safe support in line with residents' needs.

However, as outlined in outcomes 1, 3 and 10 the centre was not meeting all residents' needs. It was therefore not evident that the designated centre was resourced to ensure

the effective delivery of care and support in accordance with the statement of purpose.

Judgment:
Non Compliant - Moderate

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:
The provider had implemented some improvements since the previous inspection of the centre. However, further improvements were required to ensure staff files contained all required information, the staff rota included all staff members, training was provided for all staff and the number and ensuring the number of staff was appropriate to the number and assessed needs of residents.

Staff files did not contain all information required by the regulations. For example, details and documentary evidence of all relevant qualifications, a full employment history and the work the person performed in the centre. Furthermore, some staff files did not contain a reference from the employee's most recent employer.

Some staff files contained references from employee's previous colleagues rather than references from previous employers. It was therefore not evident that the provider had implemented an effective system to ensure that the requirements of Schedule 2 were met.

There was no system to ensure that persons employed by external organizations had all information specified in Schedule 2, for example evidence of Garda vetting, registration for nurses and appropriate training.

The staff rota had been amended to show the start and finish times of staff working in the centre and abbreviations were outlined on the bottom of the rota. However, the person in charge's start and finish times were not included on the rota.

A training needs analysis for the centre had taken place. This identified the required training for staff working in the centre. The inspector was told it would be amended and

updated as required.

Staff had not received all required training. This included training in safeguarding residents and the prevention, detection and response to abuse; fire prevention and first aid fire fighting equipment; responding to behaviour that is challenging including de-escalation and intervention techniques; first aid; dysphagia and food hygiene. In addition, some staff required updated training in manual handling.

Although the inspector was informed that staffing levels had increased to provide support for residents to access the community this was not evident in the documentation maintained (as outlined in outcome 3). The inspector was therefore not assured that the provider had addressed the finding in the previous inspection relating to ensuring the number of staff was appropriate to the number and assessed needs of residents.

Judgment:
Non Compliant - Moderate

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

Findings:
An up-to-date policy on the creation of, access to, retention of, maintenance of, and destruction of records was in place.

The policy on restrictive practices had been amended to include chemical restraint.

The risk management policy contained he risks specified in the regulations.

The policy on medication management had been amended to include guidance for staff.

The guide for residents had been amended to include all required information.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003452
Date of Inspection:	16 August 2016
Date of response:	7 October 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:
A resident was not supported to exercise his or her legal rights.

1. Action Required:
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

Please state the actions you have taken or are planning to take:
A solicitor has been identified and agreed for the resident to attend locally. The resident will be supported to exercise their wishes for their will with the support of the solicitor appointed.

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The mechanisms to ensure that each resident is consulted and participates in the organization of the designated centre had not been sustained.

2. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
• Interviews are being held on 6th to 8th October for a number of care staff and community connector positions. Residents have contributed questions that they wish to ask potential candidates. Residents have been asked if they would wish to take part in interviews. Some residents have chosen to participate in the interview process and are being supported to do so.

• Monthly residents meetings recommenced following on from the inspection. A schedule of meetings has been developed up to the end of the year for monthly meetings.

• One to one meetings have been re-established and a schedule of one to one meetings for the remainder of the year to take place on a monthly basis, is in place. These meetings are guided using a template devised within the service.

Proposed Timescale: 07/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not provided with adequate opportunities to participate in activities in accordance with their interests and capacities.

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:
Recruitment is taking place on the 6th, 7th and 8th of October 2016 for a number of vacant Social Support and community Connector Posts, which will allow the service to provide more frequent support to residents around their social and community access according to their wishes. These posts will commence as soon as all required documentation is processed following interviews.
• All Residents will be facilitated by Cheshire Ireland staff to participate in these activities. For some residents other external bodies and/or volunteers may also support them, according to their wishes. Progress on plans and participation in these activities will be recorded using the residents social support record.
• At each monthly resident meeting and one to one meeting resident's wishes will be sought on activities people would like within the service and a schedule agreed.
• The frequency of all social supports to all residents will be recorded using the social supports documentation in the resident's file.

Proposed Timescale: 30/11/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person nominated had not ensured that all complaints were appropriately responded to.

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:
• All complaints have been addressed and are currently up to date. The PPIM (Service Coordinator)/PIC are responsible for addressing complaints in order to ensure that complaints are appropriately responded to.
• The Regional Quality Officer is auditing complaints on behalf of the registered provider on a monthly basis and will communicate any outstanding issues to both the PIC and the Regional Manager.
• The Provider's Chief of Operations will be informed by the Regional Manager should any ongoing or recurrent issues occur with regard to responding to complaints.

Proposed Timescale: Completed and ongoing 30/9/16

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some complaints had not been investigated.

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

Please state the actions you have taken or are planning to take:
• All outstanding complaints have been investigated and addressed.
• One Complaint notified by the inspector on the day of the inspection was addressed and warranted a preliminary investigation as per the organisational policy. This was completed. Appropriate and documented follow up took place in relation to all other complaints

Proposed Timescale: 25/08/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A copy of the complaints procedure was not displayed in a prominent position in the centre.

6. Action Required:
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
The complaints procedure is displayed in the communal area and is accessible to residents, staff and visitors alike.

Proposed Timescale: 17/08/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have access to internet.

7. Action Required:
Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

Please state the actions you have taken or are planning to take:
Internet access which was interrupted due to the move to the new section of the building is available throughout the centre for all residents.

Proposed Timescale: 27/09/2016

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:
Some residents had not been provided with sufficient supports to develop and maintain personal relationships and links with the wider community.

8. 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:
• Recruitment is taking place on the 6th, 7th and 8th of October 2016 for a number of vacant Social Support and community Connector Posts, which will allow the service to support residents around their social and community access according to their wishes. These posts will commence as soon as all required documentation is processed following interview.
• There will be a 5 designated hours per day on the roster to support residents to access their communities.
• Residents will be facilitated by both Cheshire Ireland staff to participate in these activities, along with external bodies and volunteers where the resident chooses.
• Al supports offered will be documented using the social support record in the resident's file and these supports will be reviewed fortnightly by the PIC and PPIM during fortnightly planning sessions.

Proposed Timescale: 30/11/2016

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:
The fees to be charged were not clear for all residents.

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:
The tenancy agreement and service agreement have been reviewed for one resident and amendments made to ensure the fees charged are clear.

Proposed Timescale: 30/08/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents' personal plans were not made available in an accessible format to the residents.

10. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
Personal plans will made available in accessible format to residents who require same including in easy read or pictorial format where required. Links have been established with the wider organisation to help support this.

Proposed Timescale: 30/11/2016

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:
Some systems in place in the designated centre for the assessment, management and ongoing review of risk were not reflective of the centre.

A risk relating to access to the centre had not been identified, assessed or control measures implemented.

11. 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:
• All risk assessments classed as generic risks in the Provider's Risk Management system are being reviewed to ensure that they are reflective of the risks within the designated centre and do not include irrelevant information.
• The risk in relation to access to the centre has been addressed. Each staff member carries a fob while on duty to allow for access to the building. A bell has been installed to notify of visitors.

Proposed Timescale: 21/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some respite users and staff had not taken part in a fire drill in the centre to ensure staff and respite users are aware of the procedure to be followed in the case of fire.

Night fire drills were not reflective of the staffing levels in the centre at night.

12. 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:
A clear schedule has been put in place to ensure that all respite users and staff take part in a full fire drill. Unannounced fire drills will take place at night time and are scheduled by management at regular intervals for the remainder of the year. These will be conducted to be reflective of night time staffing levels. (i.e 2 x staff)

Proposed Timescale: 28/10/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that the systems in the centre were ensuring that residents were protected from all potential forms of abuse.

13. 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:
• An NFO6 and a preliminary investigation were completed in relation to an allegation made that poor practice related to an injury sustained by a resident.
• The PIC will attend Designated Officer Training on the 11th and 12th of October.
• The service coordinator/ PPIM will complete Designated Officer training on the 17th and 18th of October also.
• Safeguarding of vulnerable adults training will be held locally with staff to ensure they are fully aware of their duty of care in relation to reporting of abuse

Proposed Timescale: 15/11/2016

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:
The system to ensure that residents were supported to access opportunities for education, training and employment was not implemented for all residents.

14. 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:
• All residents will be supported to have an education and employment training profile completed with them, which will identify their wishes.
• Recruitment is taking place on the 6th, 7th and 8th of October 2016 for a number of vacant Social Support and community Connector Posts, which will allow the service to support residents around their social and community access according to their wishes. These posts will commence as soon as all required documentation is processed following interview.
• Residents will be supported to achieve these needs by staff of the centre including Community Connectors overseen by PIC/PPIM.

Proposed Timescale: 30/11/2016

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:
The 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 were not appropriate and suitable.

15. 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:
• Adverse event forms will be completed for all medication errors which occur and will include details of all follow up in relation to the error. All follow up will be implemented according to the centre's procedure.
• The PIC has read and is familiar with the centre's procedure in relation to medication management.
• A cross checking system is being implemented whereby the staff members who

administer medications will audit and document any errors after each dispensing of medication. This will allow for staff to identify any error as they arise and therefore support staff on medication administration to adhere to the Medication Policy. These cross checks will be reviewed by the nurse on duty on each shift and any errors communicated to the PIC.
• The Person in Charge shall hold a two weekly review of medication errors with the Staff Nurse. The review will look at recording, follow-up and management of medication errors in line with Cheshire Irelands policy, reviews will be documented.
• The Respite admission checklist documents the medication received into the service with a respite user. This procedure will be repeated when the respite user leaves the centre to ensure any omissions of medication can be identified and followed up.
• Medication Management training has taken place which has increased the number of trained staff. All shifts now have staff trained in medication management . The nursing staff PIC and PPIM's will have responsibility to ensure that each shift has staff trained in medication management.
• All errors will be followed up in a timely fashion according to Cheshire Ireland's medication Management policy
• A new post of Clinical Nurse Manager is being introduced in Mayo Services in order to ensure increased clinical governance . This post is in addition to the current nursing hours and recruitment is beginning 10th October 2016.

Proposed Timescale: 15/12/2016

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 regulations and some information was not accurately reflective of the inspector's findings.

16. 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 has been reviewed to encompass all of the information set out in schedule 1 of the regulations as is required.

Proposed Timescale: 07/10/2016

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:
The service provider did not provide evidence that the designated centre complies with the Planning and Development Acts 2000-2013 and any building bye-laws that may be in force.

17. Action Required:
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
• Internal refurbishment works carried out to the new section of the building were completed with regard to compliance with the Planning and Development acts 2013. Letters certifying this have been supplied to the authority.
• A Fire Safety certificate is being applied for pending the completion of some additional minor recommended fire upgrade works in the refurbished section of the building. These works are commencing week beginning 17/10/16 with a timescale of 9th November 2016 for completion
• Evidence of full planning compliance will be submitted to the Authority by 14th November 2016, following the completion of further minor works.

Proposed Timescale: 14/11/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place in the designated centre had not ensured that all aspects of the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

18. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
• A full time Person in Charge has commenced for Mayo Services from 25th July 2016.
• A two weekly progress update meeting will be held between the PIC and Regional Manager to ensure sustained progress on all actions listed in this action plan.
• A Regional Quality Partner will visit the centre monthly to provide oversight and support on quality improvements required within the centre. This is a new position and

increases governance. Any ongoing issues will be reported to the Regional Manager
• Clinical oversights and supports will be provided to the designated centre by the Regional Clinical Partner. Any recurring or priority issues will be reported to the Head of Clinical Services and Regional Manager
• A fortnightly planning template is being implemented to support management in having oversight of the running of the centres. This planning session has fixed agenda items such as adverse events, complaint's, medications errors and will allow for reflection, learning and planning each fortnight. These meetings will be held by the management teams within the centre, be documented and overseen by the Regional Manager.
• Supervision and support meetings will be held monthly between the PIC and Regional Manager. The Regional manager will visit the centre once monthly also. The
• The PIC ,PPIM's will hold one to meetings with each staff member on a quarterly basis to ensure that staff are supported to be aware of their performance and accountability in relation to their work.

Proposed Timescale: 07/10/16 and ongoing

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider, or a person nominated by the provider, had not carried out an unannounced visit to the centre at least once every six months.

19. 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 schedule of Unannounced audits has been created to ensure compliance with the regulations and will continue once every 6 months and be conducted within the required time period.

Proposed Timescale: 19/08/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were ineffective 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 were delivering.

20. 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:
One to one support meetings will be scheduled with all staff. These will be completed once per quarter. These meetings will support staff to be aware of their personal and professional responsibilities and the quality and safety of the services that staff are providing to our residents.

Proposed Timescale: 30/11/2016

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that the designated centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

21. 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:
Recruitment is taking place on the 6th, 7th and 8th of October 2016 for a number of vacant Social Support and community Connector Posts, which will allow the service to support residents around their social and community access according to their wishes. These posts will commence as soon as all required documentation is processed following interview.

Proposed Timescale: 30/11/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff files viewed did not contain all information specified in Schedule 2 of the regulations.

There was no system to ensure that persons employed by an external organization had all information specified in Schedule 2 of the regulations.

The provider had not implemented an effective system to ensure that the requirements of Schedule 2 were met.

22. 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 staff files are being audited in line with Schedule 2. A feedback report will be given to the PIC and action required will be addressed by the Head of Support Services in the centre and overseen by the PIC.
• Where references have been supplied by a former colleague, additional references will be sought from the employees.
• Where staff are provided by an external employer, an arrangement will be in place with the agency that all schedule 2 information will be scanned to the service prior to the staff starting any shift.

Proposed Timescale: 15/11/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff rota did not include the start and finish times of the person in charge.

23. 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:
The start and finish times of the PIC are now in place on the rota.

Proposed Timescale: 19/08/2016

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 and skill mix of staff was appropriate to the number and assessed needs of the residents.

24. 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:
Recruitment is taking place on the 6th, 7th and 8th of October 2016 for a number of vacant Social Support and community Connector Posts, which will allow the service to support residents around their social and community access according to their wishes. These posts will commence as soon as all required documentation is processed following interview.

Proposed Timescale: 30/11/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received all required training.

25. 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 full review of all training required is being carried out by the Service Coordinator and staff will be scheduled for training as required.

Proposed Timescale: 30/11/2016