

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Laurence Cheshire
Centre ID:	OSV-0003439
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Patrick Quinn
Lead inspector:	Geraldine Ryan
Support inspector(s):	Louisa Power
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
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 inform a registration decision. This monitoring inspection was unannounced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 12 July 2016 08:45 To: 12 July 2016 18:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

01 July and 02 July 2015:

an announced inspection was undertaken, over two days, to inform a registration decision. During the inspection, significant deviation from the Regulations was found with 13 of the 18 outcomes examined being judged as major non-compliant. Two immediate action plans were issued to the provider following the inspection. One immediate action plan concerned the number, qualifications and skill mix of staff, in light of the dependency levels and very high medical needs of some residents. The second action plan concerned lack of provision of sufficient mandatory training for staff.

In response to the identified failings on inspection and as part of the escalated regulatory action, the Health Information and Quality Authority (HIQA) requested the provider to attend a level 2 provider meeting, on the 5 October 2015, to inform the provider of their serious concerns and issue the provider with a warning letter.

04 December 2015:

an unannounced inspection was undertaken to follow up on the actions from the first inspection. Inspectors saw that a good level of improvement had been made. Of the 15 outcomes examined during the inspection:

- one outcome was judged to be major non-compliant
 - three outcomes were judged to be moderate non-compliant
 - 11 outcomes were judged to be compliant or substantially compliant.
- The outstanding issues of concern following the inspection included medicines management and monitoring of residents' healthcare needs.

07 January 2016: unannounced inspection:

Inspectors found that the improvements seen during the inspection of 04 December 2015 had not been sustained and found that there was limited progress made against the provider's action plan from the previous inspection in some areas.

A major non-compliance was identified in Outcome 07: Health and Safety that resulted in an immediate action being issued on the day of inspection in relation to inadequate fire safety arrangements. An adequate response within the required time lines to this immediate action plan was provided.

Inspectors found that Outcome 12: Medication management remained at the level of major non-compliance due to ongoing inappropriate medicines management practices and a lack of a rigorous response to medication related incidents.

There were inadequate arrangements in place to develop, implement and review personal plans in relation to healthcare. Based on the findings of this inspection, it was concluded that there were not effective management systems in place to sustain improvement and to ensure the delivery of a safe and consistent service.

04 March 2016:

a fourth inspection was undertaken following the receipt of an external investigation report from the provider. The report related to an adverse clinical incident that had occurred in May 2015 and had been notified to the Chief Inspector. This inspection was a triggered or 'single-issue' inspection in relation to outcome 11: Healthcare Needs. The purpose of this inspection was to seek re-assurances that residents' healthcare needs were being appropriately assessed and met by the care provided in the centre. However, outcome 11: Healthcare Needs; was judged as a major non-compliance due to the lack of adequate monitoring of residents' healthcare needs.

Other outcomes examined in this triggered, single-issue inspection were:

- Outcome 1: Rights, Dignity and Consultation; judged as substantially compliant
- Outcome 12: Medication Management; judged as a moderate non-compliance
- Outcome 18: Records and Documentation; judged as substantially compliant.

12 July 2016:

a fifth inspection was undertaken to follow up on the provider's progress in relation to the actions generated from the inspection of the 4 March 2016. The inspection took place over one day. Significant issues evidenced resulted in the issuance of an immediate action plan with regard to the inadequate nursing and clinical care needs of dependent residents.

Description of the service

The centre accommodated 23 residents:

- 10 single bedrooms in the main accommodation area. There are 3 shower rooms and 6 toilets
- nine self-contained apartments. Each apartment has an open plan design accommodating a sleeping area, living/kitchen area and a toilet/shower area. All

apartments are fully accessible.

- a four bed roomed house, which accommodates four people. All bedrooms are en-suite with a kitchen, sitting room and guest toilet on the ground floor.

The centre mainly provided a service for residents with physical disabilities and neurological conditions. One resident was in hospital at the time of inspection and one resident was on holidays.

How we gathered our evidence

Inspectors reviewed a sample of files pertaining to residents with complex co-existing healthcare needs and supports. While it was evident that residents had ready access to the general practitioner (GP) and the acute services, significant gaps were noted in residents' care planning, clinical risk assessments, nursing care records and there was a lack of adequate monitoring of residents' healthcare needs.

Practices were observed and other relevant documentation reviewed such as residents' personal care plans (PCPs), health care records, medication management records, risk assessments, accident/incident logs, the complaints log, fire safety records, cleaning schedules, staff training and the centre's policies/procedures. Inspectors met with residents and staff throughout the day and had the opportunity to sit in on a staff handover meeting.

Overall judgement of our findings

Significant non-compliances were identified which resulted in the issuing of an immediate action plan. The immediate action plan was in relation to lack of adequate monitoring of healthcare, nursing and clinical care needs of two residents. The provider's response to the immediate action plan issued on the 13 July 2016 was satisfactory; complete with actions assigned to named staff and dates specified for the completion of actions.

Inspectors found that a number of areas have yet to be satisfactorily addressed in order to ensure that residents were provided with a safe, quality service. These areas included:

Outcome 5: inadequate implementation and updating of residents' personal plans and goals which impacted on residents' opportunities to experience social inclusion and participation in activities of personal importance

Outcome 7: inadequate risk assessment processes; poor housekeeping practices; inadequate practices in relation to the prevention of infection

Outcome 8: assessment of restrictive practices was not conducted as per the centre's policy on the use of a restraint

Outcome 11: some health care interventions were not supported by written documentation from allied professionals and did not reflect the real, assessed needs of the residents. Some care planning was generic and not dated or signed off by relevant staff. Significant gaps were noted in nursing and care staff records (fluid balance records, oral care, pressure area skin care)

Outcome 12: unsafe medication management practices

Outcome 14: inadequate auditing of the quality of care by the provider and inadequate supervision in the centre

Outcome 17: staff training; not all staff had attended relevant/mandatory training; no clarification with regard to the training agency staff had attended

Outcome 18: some practices concerning medication did not concur with the centre's policy on medication management.

A second level 2 provider meeting was held with the provider representative in HIQA's head office on the 20 July 2016 to discuss the significant failings from the inspection of the 12 July 2016. At this meeting, attended by both the provider and organisation's interim head of operations/acting chief executive officer, HIQA set out the expectations of the provider on what needed to be undertaken to bring the centre into compliance and requested a robust action plan response to address these serious and repeated failings. In addition, the provider was put on notice as to the consequences of the continued non-compliances and that HIQA would use its statutory powers as required to ensure residents health and welfare was protected in this centre.

The provider was afforded two opportunities to submit a satisfactory response to the actions generated by this inspection; both responses were rejected, and not published, on the basis that the responses were insufficient and not robust to address the actions generated.

Subsequently, on the 28 August 2016, the provider was issued a Notice of Proposal to refuse the registration of the centre, with a statutory 28 day timeline within which the provider could submit a response to the Notice of Proposal to refuse registration. The provider's response was received on the 28 September 2016.

Following a review of this, the provider's representative response was rejected as it did not address in a satisfactory manner all matters outlined in the grounds of the notice of proposal to refuse. Furthermore, the decision was taken to undertake an unannounced inspection with a particular focus of the healthcare needs of residents with complex clinical and nursing care requirements and to inspect the alleged progress as outlined in the provider representative's response to the Notice of Proposal to refuse registration.

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

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed five of the residents' person centred plans (PCPs). On perusal of residents' personal care plans (PCPs), it was difficult to retrieve relevant and up to date and accurate information as information contained therein was conflicting and disjointed. Information was not collated in an organised manner to ensure staff had access to the most up to date guidance. Each resident had four folders containing information pertinent to them. Overall, inspectors were not satisfied that the residents' PCPs identified the services and supports required to ensure that residents led enriched lives.

The person in charge informed inspectors that residents had access to:

- physiotherapy two days per week for a total of nine hours
- speech and language; on a referral basis and to an external practice in a town 37kms from the centre
- occupational therapy (OT) had been available to residents; the person in charge stated that the organisation was at the interview process of recruiting another OT
- psychiatry services is through referral by the general practitioner (GP)
- psychology services is through referral.

Residents had access to dental, optical and chiropody services. While there was evidence of multidisciplinary involvement and review, there was little evidence that that the plans were reviewed through the convening of the person centred planning meeting between the multidisciplinary team members, staff members, relatives and the resident themselves, and on an annual basis.

While each resident had a PCP, the plan did not outline the services and support to be provided to achieve a good quality of life, to realise their goals or to improve their personal development. The social aspect of the residents' PCP reviewed did not capture or identify any goal a resident may like to achieve, the arrangements required to be put in place to help the resident achieve a goal and who was responsible to support the resident and by when. This was discussed with the provider representative and the person in charge at the feedback meeting held at the end of the inspection. Both concurred with the inspectors' observations and stated that this element of the PCPs was next to be progressed.

In addition, it was not demonstrated how the effectiveness of the personal plan was evaluated. For example, a described intention for one resident concerned a matter that was of significance personal importance to him/her. However, the responsibility for the resident to achieve this was assigned to 'all staff' and the estimated time to achieve this was 'ongoing'. This was dated 23 March 2016 and the person in charge confirmed that, to date, no progress had been made on this matter.

Some PCPs were completed in consultation with the resident and others were not; for example; staff confirmed that one resident was able to communicate his/her needs and would be able to participate in the review of his/her PCP and confirmed that the resident was not consulted.

There was evidence that residents had access to a range of activities, internal and external. However, none of the PCPs reviewed reflected this information nor identified the resident's individual needs, choices and aspirations in relation to such opportunities.

There was evidence of ongoing discussions with residents who expressed a wish/goal to move to different accommodation with provisional plans in place.

There was no evidence that residents' personal plans were made available to them in an accessible format.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

On the day of inspection the centre did not have an up to date health and safety

statement. The health and safety statement was dated 2006. This was forwarded to the Authority the day after the inspection.

While the centre had a risk register, the specific risk as outlined in Regulation 26 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 concerning self-harm was not included.

The centre had an environmental risk register, however clinical risks were not identified, risk rated with control measures or put in place to mitigate the risk.

While resident specific risk assessments were in place, the control measures in place were not robust, for example:

- inappropriate risk assessment dated 3 March 2016 and reviewed on June 2016 of a resident with a specialised catheter. The documented 'control measure' included 'nurse on duty needs to prioritise their workload if a resident requests their catheter to be flushed'
- one resident with complex co-existing conditions had a risk assessment in relation to the care of their pressure area of their skin. The control measures documented were not informative to guide staff and in particular agency staff. It included information such as 'rub areas 2-4 hourly when in bed', 'to be on a mattress specific to prevent pressure sores'. There was no further guidance on the type of mattress currently used and no information in relation to positioning the resident
- a resident unable to communicate their needs; the resident's risk assessment highlighted the inability to communicate, with a control measure guiding staff to 'carry out regular checks'. There was no guidance on how regular the checks were to be carried out or what format such checks should occur.

- a resident's risk assessment referenced that a audio visual monitor had been purchased to monitor the resident. The control measure included that an operating procedure be put in place for the video monitor. This information was dated 15 December 2015. The provider, post the inspection of 4 March 2016, had received a regulatory action in relation to this matter and the provider's response included that the use of CCTV ceased on the 8 March 2016. However, on this inspection, while it was noted that the use of CCTV in the resident's bedroom had ceased, the risk assessment noted in the resident's files was not updated and still indicated that a video monitor had been purchased to monitor the resident and furthermore the associated risk assessment had been reviewed on the 2 April 2016; nearly four weeks after the CCTV had been removed

- one resident had two risk assessments for the use of a lap belt. One risk assessment informed staff to 'open the lap belt every two hours' and the second risk assessment did not contain this information. Both were signed as being reviewed on the 2 April 2016

- one resident had two risk assessments referencing their ability to communicate; however one risk assessment stated that the resident 'can call out and verbalise needs', the second risk assessment stated that the resident was unable to 'vocalise for assistance'.

The centre had a procedure to follow in the event a resident goes missing.

The staff training matrix was reviewed and training for staff on safe manual handling practices was outstanding for 11 staff. Perusal of same indicated that some staff had not attended training since

- 2011 - one staff
- 2012 - one staff
- 2014 - one staff
- date when two staff last attended training was unclear as both staff were highlighted as requiring refresher training
- no information was recorded for six staff.

The aspect in relation to the cleanliness of the centre was examined on this inspection. The following observations were evidenced:

- two domestic fridges storing daily products, one located in the dining room and one in the kitchenette, did not have a thermometer for staff to record the temperature of the fridges contained food and liquids
- the trolley used to transport perishable food was unclean; the trolley contained residue and crumbs; was stained and the trolley wheels were grimy with unidentifiable matter on them
- a cutlery container in the dining room was visibly unclean and contained dirty residue. A staff member concurred with this
- radiators located in residents' bedrooms and throughout the centre were dusty and visibly stained
- a radiator located in a shower room was visibly rusty
- shower trolleys used by residents were visibly dirty and there was no evidence of a cleaning schedule for same
- some shower chairs were unclean. Urine and faecal staining was noted. One shower chair was rusty
- the laundry trolleys frames were visibly dirty and laundry trolley covers were stained and unclean
- a scissors was inappropriately located on a window frame in an assisted bathroom
- a waste paper pedal bin in one of the bathrooms did not open
- hoists stored on the corridor and in a store were visibly dusty and dirty
- storage presses located on a public corridor were not secured in a safe manner; presses were secured with paper tape wrapped around the handles. These storage presses stored residents' personal effects and this was confirmed by staff
- the housekeeping press where cleaning agents and cleaning utensils was unclean and untidy
- the fire hose reel was dusty.

The colour coding of one bucket used for cleaning did not concur with the centre's guidance. Inspectors were informed by staff that they were waiting on the purchase of a required cleaning bucket and in the interim were instructed to use another bucket. There was no information available for staff to follow in relation to deep cleaning procedures. This was confirmed to inspectors by a staff member.

Flooring, wall tiles in bathrooms were scuffed and in a state of disrepair.

The inspector noted that an infection prevention and control review was carried out by a specialist infection prevention and control nurse on the 15 March 2016 with a follow up visit on the 23 March 2016. The resultant report arising from this review, dated 4 April 2016, outlined findings some of which were observed on inspection on this inspection of the 12 July 2016. The report of the 4 April 2016, outlined recommendations for improvement with a column for the actions taken by the provider. However, on review there was no evidence that the report was actioned, or persons identified with the responsibility for completing an action and by when.

Suitable fire equipment was provided and there was evidence that the fire equipment, the fire alarm and emergency lighting were serviced by a suitably qualified person. Daily fire checks were carried out. The fire safety policy was last reviewed on the 25 February 2016.

There was evidence that staff and residents participated in fire drills. The inspector reviewed documentation pertaining to three fire drills dated 25 May 2016, 25 June 2016 and 5 July 2016 and noted the following:

- the timing of two fire drills varied between four and 20 minutes. A completion time was not logged for the third drill carried out.

While areas for improvement were identified post the fire drills, there was no evidence that these were actioned or by whom. For example; torches were noted as not being available for one fire drill dated 25 June 2016 and there was no evidence that the torches were subsequently provided. This was highlighted to the person in charge who was not sure if the torches were available.

There was evidence that fire warden 'Peer Group Refresher sessions 'were held. Topics discussed included for example; use of ski sheets; use of two-way communication devices and fire safety procedures.

Inspectors noted that the centre had a ski sheet checklist for each resident. A ski sheet is an evacuation tool for residents who are immobile and features as part of the fire warden training. The person in charge stated that the ski sheets were checked on a daily basis. However, there was documented evidence that this did not occur. A ski sheet checklist of an immobile resident was reviewed and numerous gaps were noted; for example;

- the ski sheet was not checked in January 2016
- checked once in February 2016
- checked six days in March 2016
- checked twice in April 2016
- checked four days in May 2016
- checked five days in June 2016
- no checks logged for July 2016.

Furthermore, noted on the ski sheet checklist was that this record was to be completed every time the bed linen is changed. There was no documented evidence to support that staff complied with this instruction.

It was also noted and documented on the risk assessment pertaining to ski sheets that the ski sheets were to be checked weekly.

The staff training matrix was reviewed and training for staff on fire safety was outstanding for 7 staff. The following was noted where some staff had not attended

mandatory fire safety training:

- 2009 - one staff
- 2010 - one staff
- 2010 - one staff
- 2012 - one staff
- 2014 - one staff
- there was no information recorded for two staff.

The status of fire safety training for agency staff was unclear.

There was a prominently displayed procedure for the safe evacuation of residents in the event of a fire.

Each resident had a personal emergency evacuation plan.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

Findings:

The matter of restrictive practices in the centre requires review as the centre was not complying with its own policy, national policy and evidence-based practices. The centre's policy states that a systemic and collaborative assessment of the need for restraint by a multidisciplinary assessment team will be initiated by the service manager. The multidisciplinary assessment was undertaken by the person's GP, or treating specialist, the physiotherapist, OT and the person (resident) their family and or advocate. There was evidence that the assessment process as outlined in the centre's policy was not complied with. This matter was discussed with the person in charge who was not aware of this aspect of the centre's policy on the use of restraints. Also, the staff training matrix did not capture any training for staff on the use of a restrictive practice.

Safeguarding and quality assurance of restrictive practices was poor. There was no evidence that the record of checks of a restrictive practice was regularly overseen by management. Conflicting guidance was noted; for example; a clinical risk management

plan, reviewed on the 2 April 2016, clearly stated that the resident was to be visually checked every two hours. There was no mention that the lap belt was to be released at any time. However, another risk assessment form contained a control measure guiding staff to 'open lap belt every two hours and record same in the care plan'. This was not evident in the care plan. Another document perused by inspectors and for the same resident, noted that the resident was checked, but there was no reference to opening the lap belt for the intervals directed in the second risk assessment. Staff spoken to were unsure of when lap belts were to be released and stated that it did not happen regularly and were unaware that the release was to be recorded.

Not all staff had attended mandatory training on managing behaviours that challenge. While the person in charge stated that no resident exhibited a behaviour that may challenge, inspectors were informed by the CNM2 of an incident where a resident voiced they would self harm; this specific risk was not captured in the risk register.

Documented information to guide and inform staff in relation to residents' intimate care plans were not robust and did not give clear guidance to staff, particularly agency staff, on this matter.

Arrangements were in place to ensure that all disclosures of incidents, allegations or suspicions of abuse were appropriately investigated and responded to in line with the centre's policy, national guidance and legislation.

The incidents log was reviewed and while there was detailed recording of incidents, there was no evidence that learning gleaned from incidents and or accidents was disseminated to staff or informed a resident's care plan. For example; a particular instruction from a surgical consultant was in place for a resident. The instruction was not followed by staff and resultantly this had a serious consequence for the resident.

The provider was unable to demonstrate that agency staff had completed safeguarding or training in challenging behaviours.

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):

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

Findings:

The day after the inspection, a case meeting was held in HIQA on the 13 July 2016 to discuss the concerns identified on the inspection. The outcome of this meeting was the issuance of an immediate action plan to the provider representative for the following reasons:

A resident with co-existing complex medical and nursing needs had:

- a particular instruction in relation to wound care. This instruction was not followed and resulted in a deterioration of the resident's wound and subsequent admission to an acute hospital
- the required clinical oversight and monitoring of a resident's fluid intake was not adhered to. The specialist advice with regard to a stated fluid intake over a 24 hr period was not followed. This resulted in the resident receiving in excess of the advised intake of fluids.

Another resident with co-existing complex medical and nursing needs was assessed as being at a high risk of choking;

- inappropriate risk assessment of a choke episode dated 10 April 2016; documented control measures included 'speaking to resident', 'provision or not of night snacks', 'if drowsy in appearance'
- there was no consistent log recorded of the care of this resident's specialised catheter care or consistent recording of when the specialised catheter was changed and or flushed
- inappropriate risk assessment dated 3 March 2016 and reviewed on June 2016 of a resident with a specialised catheter. The documented 'control measure' included 'nurse on duty needs to prioritise their workload if a resident requests their catheter to be flushed'
- had a battery operated pump reinserted at an acute hospital for the regular administration of a medication. The documented specific guideline with regard to the care of the wound dressing that came from the specialist team was not captured in the nurse's notes or in the resident's care plan to guide staff on this matter.

The provider representative was contacted and informed that an immediate action plan was being issued.

Other findings on the inspection of the 12 July 2016 included the following:

A resident had schedule of stretching exercises recommended by a physiotherapist (to be performed at least three times daily); there was no evidence that the resident was facilitated or aided to carry out the daily programme.

Numerous and significant gaps were noted on the resident's exercise sheet; for example; there was no documented evidence that the resident had been facilitated to carry out exercises between; for example:

- 3 February 2016 to the 13 February 2016
- 15 February 2016 to the 20 February 2016
- 22 February 2016 to the 5 March 2016
- 7 March 2016 to the 7 May 2016.

Records reviewed indicated that the resident was facilitated to exercise eight days during May 2016. Neither the person in charge or staff were not able to demonstrate why this occurred.

For one resident a swallow observation chart reviewed indicated that there was no issues with observation/swallow. However, the inspector heard stated at the staff handover report on the 12 July 2016 that this resident experienced some difficulty with swallowing the previous day. Noted on the resident's swallow observation chart for the 11 July 2016 was 'no issues'.

Also, it was not clear if the resident's total fluid intake was to be recorded and commented on in this chart as entries did not correspond with another fluid record chart in use for the resident's fluid balance intake/output for that time. Guidance for staff on this matter was not clear on either chart.

A resident's weight record indicated that the resident's weight was to be recorded on a monthly basis. However the resident's weight was not recorded in February 2016 or March 2016. There was also an instruction that the resident's blood pressure was to be recorded monthly. However, the resident's blood pressure had not been recorded from August 2015 to 29 May 2016. The resident's blood pressure was recorded for June 2016.

The plan of care for one resident, who required full assistance with meals and fluids, indicated that the resident's oral care was to be performed three times a day. For example; the resident's oral care chart reviewed indicated that between the dates of the 2 July 2016 to the morning of the 12 July 2016, the resident's oral care was carried out twice per day (morning and night time). Furthermore, once in 13 days was the resident's oral care attended to during or post lunch time. It was not clear from speaking with staff if the resident's oral care was carried out on a regular basis.

A resident with maximum dependency needs and complex nursing care requirements was on a fluid intake and output record. Perusal of these records indicated that:

- the resident's fluid intake was not always totalled for the 24 hours; for example; 24 June 2016, 26 June 2016 and 27 June 2016, 8 July 2016

- the resident's urinary output was not totalled on a number of days; for example; 24 June 2016, 25 June 2016 and 26 June 2016; 8 July 2016 and 9 July 2016

- gaps were noted where there was no evidence that a resident received fluids as no fluid intake was documented; for example;

26 June 2016; 02:00hrs - 200mls juice. Next fluid entry noted was 12md - 180mls juice (10 hours later)

28 June 2016; 10:00hrs - 200mls juice. Next fluid entry noted was 17:30hrs (seven and a half hours later)

8 July 2016; 13:00hrs - 200mls water. Next fluid entry noted was 21.30hrs (eight and a half hours later)

- the fact that the resident had a catheter to aid urination was not documented on the fluid balance charts reviewed

- an entry noted in the daily communication sheet dated 11 July 2016; 16:00hrs was the fact that '250mls was emptied from the catheter bag'. However, this was not documented in the output column of the fluid balance record chart.

Another record sheet for recording the resident's catheter care did not include information when the resident's catheter was changed.

Another resident with maximum dependency needs and complex nursing and medical care requirements was on a restricted fluid intake. However, on a review of six days prior to an emergency admission to hospital, there was evidence that the oral intake of fluids:

- exceeded the stated intake on one day
- was not totalled for one day so there was no indication as to what fluids the resident actually had
- was incorrectly totalled for one day
- no urinary output was recorded for four of the six days. This was discussed with the person in charge and the provider representative at the feedback meeting.

This resident was on monthly weights. However, the resident's weight was not recorded on October 2015, November 2015, January 2016, February 2016 or June 2016. Recommendations from the dietician dated 31 May 2016 were not included in the resident's PCP.

Inspectors wish to acknowledge the detailed and individualised knowledge the chef demonstrated with regard to the dietary requirements of the residents. A comprehensive folder containing residents' likes, dislikes and dietary recommendations was in place. Systems, processes and workflows within the main kitchen were ably demonstrated by the chef.

Subject to the findings on this inspection, the provider representative and their manager were required to attend a meeting with the Authority on the 20 July 2016.

Judgment:

Non Compliant - Major

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

At the previous inspection in March 2016, a judgment of moderate non-compliance was made in relation to medicines management due to ongoing inappropriate medicines management practices.

On this inspection, inspectors saw that unsafe medicines management practices were evident and a judgment of major non compliance was made.

The medication related incident forms generated since the 01 April 2016 were reviewed by an inspector. A total of 43 medication related incidents had been reported; 39 of which were attributable to practices within the centre. A number of these errors were deemed to be potentially serious and some were recurrent errors within a short period. An incident had occurred where the second and third doses of an antibiotic medicine were omitted and a resident did not receive antibiotic cover for 24 hours. On two occasions, medicines were given at the wrong time, i.e. medicines prescribed for the evening had been administered in the morning and vice versa.

On two occasions, a resident's pain patch was not applied on time, with a delay of two days on one occasion and 3.5 hours on another.

The person in charge and the clinical nurse manager outlined that a meeting to review the incident was held after each incident and learning was identified. The records of these meetings were reviewed and the inspector saw that the actions following the meetings were generic. The review of medication related incidents was not multifactorial and focused on the operator rather than a systems-based approach. Therefore, it was not demonstrated that all aspects of the medicines management cycle had been reviewed to prevent recurrence of a potentially catastrophic medication-related incident. The impact of such medication related errors could potentially be catastrophic and therefore, a judgment of major non compliance was made.

Judgment:

Non Compliant - Major

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

Findings:

A governance and management structure was in place. The person in charge informed inspectors that her post was full time and she was engaged in the governance, operational management and administration of the centre.

The person in charge said she had good support from the regional manager who was also the provider representative. The management structure in the centre had been

augmented with the employment of two clinical nurse managers (CNM1 and CNM2). Both were on duty on the day of the inspection.

However, in order to sustain improvement and to ensure the delivery of safe, quality care to residents, the significant findings on this inspection indicated that there were not effective management systems in place; for example;

Outcome 5: inadequate implementation and updating of residents' personal plans and goals which impacted on residents' opportunities to experience social inclusion and participation in activities of personal importance

Outcome 7: inadequate risk assessment processes; poor housekeeping practices; inadequate practices in relation to the prevention of infection

Outcome 8: assessment of restrictive practices was not conducted as per the centre's policy and national policy on the use of a restraint

Outcome 11: some health care interventions were not supported by written documentation from allied professionals and did not reflect the real, assessed needs of the residents. Some care planning was generic and not dated or signed off by relevant staff. Significant gaps were noted in nursing and care staff records (fluid balance records, oral care, pressure area skin care)

Outcome 12: unsafe medication management practices

Outcome 14: inadequate auditing of the quality of care by the provider and inadequate supervision in the centre

Outcome 17: staff training; not all staff had attended relevant and mandatory training; no clarification with regard to the training agency staff had attended

Outcome 18: some practices concerning medication did not concur with the centre's policy on medication management.

Inspectors found clear evidence to support that the quality of care of the residents, and in particular residents with complex co-existing conditions with significant medical, nursing and clinical care needs, was not adequately monitored on an ongoing basis. There was insufficient clinical oversight to ensure that the recommendations from specialist allied professionals were included in residents' PCPs. Systems in place did not support and promote the delivery of quality and safe care.

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:

Residents' complex medical, nursing and clinical needs could not be met as staff members lacked the required skills to support and care for residents. The inspector reviewed a copy of the updated staff training matrix submitted by the person in charge the day after the inspection carried out on the 12 July 2016. While the training matrix depicted a wide range of training for staff, the following was noted:

Nursing staff:

- no nursing staff had attended training on dysphagia (a difficulty in swallowing) and this was confirmed by the person in charge
- two staff nurses had not attended mandatory training in safeguarding a vulnerable adult
- three staff nurses had not attended mandatory manual handling training
- one staff nurse had not attended mandatory training in fire safety
- two staff nurses had not attended mandatory training in management of behaviour that is challenging
- three staff nurses had not attended training on epilepsy and the administration of buccal medication (administration of a particular medication in the event of a resident having a seizure
- no staff nurse had attended training on hand hygiene

No nursing or care staff had attended training on the prevention of infection; pressure ulcer care; diabetes; stoma care; bowel care; catheter care; care of a resident at end of life; pain management, risk management or training on how to thicken fluids before administering a drink to a resident at risk of choking.

The clinical nurse manager two, the clinical nurse manager one and a staff nurse had no training on medication management training.

Care Staff and non care staff:

The training matrix evidenced that training was outstanding for some staff on safeguarding of vulnerable adults (one staff); fire safety (seven staff); medication management (three staff); positive behaviour support (one staff); dysphagia (16 staff); food hygiene (24 staff); epilepsy and buccal medication (9 staff); hand hygiene (40 staff approximately); manual handling (11 staff).

No staff had attended training on the prevention of infection, diabetes, bowel care, catheter care or care of a resident at end of life.

Communication training for staff was not included in the staff training matrix. The provider's response to the inspection carried out on the 4 December 2015 stated that training for staff in this matter was to be completed by 22 February 2016. There was no evidence that this had occurred.

The staff training matrix did not capture any training for staff on the use of a restrictive practice.

Cognisant of the nursing and healthcare needs of some residents accommodated in the centre it was evident that staff were not facilitated to attend training to promote and ensure the safe care of the residents accommodated in the centre. A number of residents were assessed as being at a high risk of choking. However, none of the staff nurses had attended training on this matter.

A number of residents had a wound, however no staff had been facilitated to attend training on wound care and pressure ulcer management.

It was unclear as to what training agency staff had attended.

It is of significant concern to the Authority, conscious of the significant nursing and healthcare needs of some residents with complex co-existing conditions that the centre did not have adequate arrangements in relation to nursing oversight on duty at night. The person in charge stated that this had been reviewed and that she was satisfied that three care staff on night duty was sufficient.

However, the arrangements at night for nursing and health care provision and monitoring for some residents with nursing and healthcare needs and complex co-existing conditions, was of particular concern to inspectors due to the following:

- some residents had significant nursing and or clinical care requirements
- some residents require the assistance of two and or three staff at any one time
- some residents were not physically able to use the call bell system to summon assistance
- night staff were required to go over to a house two or three times a night to attend to residents' needs.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

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

Theme: Use of Information
Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.
Findings: Only the aspects relating to the outcomes reviewed on this inspection were examined. The medicines management policy had been updated and reviewed in March 2016. Many elements of the policy were comprehensive and evidence based. However, the policy required review to include the administration of all emergency medicine prescribed in the centre for use in a seizure. The section in relation to the role of the pharmacist did not reflect the provider's obligations under Regulation 29 (1) and Regulation 29(2). In addition, some aspects of the medicines management policy were not implemented in the centre including the plan for residents who receive 'as required' medicines.
Judgment: Substantially 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:

Geraldine Ryan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003439
Date of Inspection:	12 July 2016
Date of response:	

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

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

Not ensuring that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Proposed Timescale:

Theme: Effective Services

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

Residents' person care plans did not outline the services and support to be provided to achieve a good quality of life and to realise their goals. The social aspect of the residents' PCP reviewed did not capture or identify any goal a resident may like achieve, the arrangements required to be put in place to help the resident achieve a goal and who was responsible to support the resident and by when.

2. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Proposed Timescale:

Theme: Effective Services

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

Not ensuring that that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

3. 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:

Proposed Timescale:

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:

Not ensuring that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

4. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

Proposed Timescale:

Theme: Effective Services

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

Not having robust systems in place in the designated centre for the assessment, management and ongoing review of risk.

5. 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:

Proposed Timescale:

Theme: Effective Services

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

Not ensuring that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

6. Action Required:

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

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

Proposed Timescale:

Theme: Effective Services

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

Not all staff had received suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

7. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

Proposed Timescale:

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Restrictive procedures including physical, chemical or environmental restraint are used, were not are applied in accordance with national policy and evidence based practice.

8. Action Required:

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

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

Proposed Timescale:

Theme: Safe Services

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

Not all staff had attended training in the management of behaviour that is challenging including de-escalation and intervention techniques.

The provider was unable to demonstrate that agency staff had completed safeguarding or training in challenging behaviours.

9. Action Required:

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

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

Proposed Timescale:

Theme: Safe Services

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

Not ensuring a restrictive practice was released on a regular basis.

10. 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:

Proposed Timescale:

Theme: Safe Services

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

Not all staff had attended training in relation to safeguarding residents and the prevention, detection and response to abuse. The provider unable to demonstrate that agency staff had completed safeguarding or training in challenging behaviours.

11. Action Required:

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

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

Proposed Timescale:

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Not facilitate the medical treatment that is recommended for each resident and agreed by him/her.

12. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

Proposed Timescale:

Theme: Health and Development

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

Individual residents' health care needs were not appropriately assessed and met by the care provided in the centre.

Residents' health care plans did not reflect the real assessed health needs of the residents:

One resident had a particular instruction in relation to wound care. This was not followed and resulted in a deterioration of the resident's wound.

Residents' clinical risk assessments require review and oversight.

Residents' documentation pertaining to fluid intake/output; monthly weights and monitoring of blood pressure require review and oversight.

Recommendations from allied professionals were not included in the residents' care

plans or carried out as per instructions.

13. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

Proposed Timescale:

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:

A number of potentially serious medication related errors were reported.

The review of medication related incidents was not multifactorial and focussed on the operator rather than a systems-based approach.

14. 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:

Proposed Timescale:

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:

Not having systems in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

15. 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:

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

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

Not ensuring that the number 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.

16. 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:

Proposed Timescale:

Theme: Responsive Workforce

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

Not ensuring that that where nursing care is required, subject to the assessed needs of residents, it is provided.

17. Action Required:

Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

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

Proposed Timescale:

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Not ensuring that residents receive continuity of care and support, particularly in circumstances where agency staff are employed.

18. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

Theme: Responsive Workforce

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

Residents needs could not be met as staff members lacked the required skills to support and care for residents.

Nursing staff:

- no nursing staff had attended training on dysphagia and this was confirmed by the person in charge
- two staff nurses had not attended mandatory training in safeguarding a vulnerable adult
- three staff nurses had not attended mandatory manual handling training
- one staff nurse had not attended mandatory training in fire safety
- two staff nurses had not attended mandatory training in management of behaviour that is challenging
- three staff nurses had not attended training on epilepsy and the administration of buccal medication (administration of a particular medication in the event of a resident having a seizure
- no staff nurse had attended training on hand hygiene

No nursing or care staff had attended training on the prevention of infection; pressure ulcer care; diabetes; stoma care; bowel care; catheter care; care of a resident at end of life; pain management, risk management or training on how to thicken fluids before administering a drink to a resident at risk of choking.

The clinical nurse manager two, the clinical nurse manager one and a staff nurse had no training on medication management training.

Care Staff and non care staff:

The training matrix evidenced that training was outstanding for some staff on safeguarding of vulnerable adults (one staff); fire safety (seven staff); medication management (three staff); positive behaviour support (one staff); dysphagia (16 staff); food hygiene (24 staff); epilepsy and buccal medication (9 staff); hand hygiene (40 staff approximately); manual handling (11 staff).

No staff had attended training on the prevention of infection, diabetes, bowel care, catheter care or care of a resident at end of life.

The staff training matrix did not capture any training for staff on the use of a restrictive practice.

Communication training for staff was not included in the staff training matrix. The provider's response to the inspection carried out on the 4 December 2015 stated that training for staff in this matter was to be completed by 22 February 2016. There was no evidence that this had occurred.

A number of residents had a wound, however no staff had been facilitated to attend training on wound care/pressure ulcer management.

It was unclear as to what training agency staff had attended.

19. 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:

Proposed Timescale:

Theme: Responsive Workforce

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

Not ensuring that staff are appropriately supervised, particularly at night.

20. 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:

Proposed Timescale:

Outcome 18: Records and documentation

Theme: Use of Information

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

Some aspects of the medicines management policy required review.

21. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

Proposed Timescale:

Theme: Use of Information

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

Some elements of the medicines management policy had not been implemented.

22. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Proposed Timescale: