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:	Adults Services Palmerstown Designated Centre 2
Centre ID:	OSV-0003899
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stewarts Care Limited
Provider Nominee:	Brendan O'Connor
Lead inspector:	Caroline Vahey
Support inspector(s):	Karina O'Sullivan
Type of inspection	Unannounced
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
13 July 2017 08:15	13 July 2017 20:05

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection.
This was an unannounced inspection, the outcome of which will inform a registration renewal decision. This was the fourth inspection of the designated centre and nine outcomes were inspected against. The centre was previously inspected in November 2016.

Description of the service.
The centre provided residential accommodation to 30 residents on a campus based setting. Both males and females could be accommodated and there were no vacancies on the day of inspection.

How the inspectors gathered evidence.
The inspectors observed practice on the morning of the inspection in three units in terms of the care and support provided to residents and visited the two other units on the afternoon of the inspection. The inspectors spoke with fourteen staff members in relation to the services provided to residents and also met with the person in charge on the afternoon of the inspection. The director of care as well as the service compliance manager met with inspectors during the day. Relative or friend questionnaires were also reviewed, as well as documentation such as personal

plans, restrictive practice prescription, fire safety records, medication prescriptions and administration records, staff rosters and six monthly unannounced visits.

Overall judgement of findings.
Major non compliances were identified in eight of the nine outcomes inspected against. The inspectors found residents were not supported with an acceptable standard of care and support resulting in poor outcomes for residents. There was evidence of institutional type practices and care, and residents' privacy and dignity was compromised by practices in the centre. Residents were not supported to engage in meaningful activities and residents were observed to spend a significant amount of time sitting around with no opportunities for positive engagement provided. Residents healthcare needs were impacted by a lack of staff knowledge and residents were put at risk due to inconsistent and unfamiliar staff providing care. There was evidence of poor infection control and residents' basic right to safe hand hygiene care was not upheld. Two immediate actions were issued to the provider in relation to healthcare and infection control. The provider outlined the actions they had taken to mitigate the risks by the end of the inspection, however on attendance at one unit, the inspectors found infection control measures had not been addressed. Residents had not been safeguarded against incidents of abuse, and further safeguarding issues observed on inspection, had not been identified by the provider and as such appropriate measures to protect residents were observed not to be in place. Risks were also identified in medication management and in the identification and response to adverse incidents involving residents. There were insufficient staffing levels and inconsistent staff provided and staff were found not to be sufficiently knowledgeable on residents' needs in order to ensure the safe and appropriate delivery of care.
Overall the inspectors found the provider had failed in their requirement to provide a safe and appropriate service, having regard for the assessed needs of residents. There was a lack of robust monitoring of the service provided, resulting in poor outcomes and continued exposure of residents to risk.

These findings are discussed in the main report and the regulations which are not been met in the Action Plan at the end of the report.

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

Outcome 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:
The inspectors found residents' privacy and dignity was not upheld by practices and facilities in the centre and residents rights were not protected in the use of restrictive practices. There was evidence of institutional type practices in the centre.

The inspectors observed that practices and interventions impacted on residents' privacy and dignity. In one unit, a resident was observed to walk into the communal area from the bathroom on three occasions in a state of undress. The inspectors found this resident had not been appropriately supported to prevent these incidences and in order to maintain their dignity. In another unit, the inspectors observed a number of residents with exposed lower body, inappropriately dressed, over a prolonged period of time.

In one unit, two residents shared a room, however, while protective screening had previously been in use in this room, staff showed the inspectors that this screening was now broken, and a suitable replacement had not been sourced to date. In this same unit staff told inspectors that a number of residents frequently entered other residents' bedrooms, and took personal items such as undergarments and hygiene products.

The inspectors found that the practice of 15 minute checks throughout the night time in some units did not ensure residents' privacy was maintained. These practices were not informed by up- to- date assessments and evidence was not available to confirm more suitable interventions were tried to limit these interruptions to residents.

There was evidence of institutional type practices in the centre. The inspectors observed

a staff during a mealtime, put protective wear on a resident and then laid this protective wear across the table and subsequently placed the resident's meal / bowl on top of the protective wear. In another unit residents were observed to wear plastic disposable aprons during meals however, staff reported to inspectors the residents in this unit did not required these aprons while availing of public amenities.

In one unit staff reported that some residents had difficulty with their sleep pattern and on occasions this was impacted by early morning deliveries to the unit. At times these deliveries could be as early as 6.30am.

The inspectors found the use of environmental restrictive practices did not ensure residents' rights to access their home were protected. There were several internal locked doors observed in units however, evidence was not available to confirm the use of these practices had been assessed as required in response to risk. Staff told the inspectors that at times these practices were in place due to a lack of staff supervision for residents.

Personal information contained in nursing reports was found to be left in a communal area of one unit, and in another unit, health assessments were displayed on noticeboards in a communal area of the unit.

In one unit where concerns had been raised in relation to the service provided, there was no evidence that this had been recorded as a complaint and as such actions taken to investigate and act on this concern.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The inspectors found residents were not supported with meaningful daily activities in

order to meet their social care needs. Up-to-date plans were not in place in relation to some residents' social care goals.

On the morning of the inspection, most residents in one unit were observed to be sitting around in the main sitting room, and were not engaged in activities. For the majority of these residents, no activity was offered to residents. One resident requested to go for a walk mid morning however, was asked to wait until staff breaks were over. Two hours later this resident had still not been brought for a walk and staff cited this was due to a staff being too busy. During this period of two hours the inspectors observed that for a period of time three staff were engaged in sorting laundry. Two residents of the eight in the unit were observed to be facilitated in the morning with an activity, one resident went for a walk, and one resident was brought shopping to purchase food.

In a second unit, similar findings were found, and residents were not supported to engage in social activities. On the day of inspection, some staff were not aware of the social goals of residents. The inspectors reviewed social care plans however, these plans were found not to be up-to-date and the person in charge was unable to locate up- to-date plans.

However, the inspectors found the compatibility of residents, in particular in one unit remained an issue and impacted on residents' quality of life. The provider acknowledged this remained an issue and outlined funding had been approved for additional measures to mitigate some risks in this unit.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The inspectors found that improvements were required in aspects of some unit to ensure residents were safe and risks mitigated.

Aspects of one unit required improvements. The inspectors observed screws protruding from a door fixing and skirting boards in poor decorative repair around this door. Plaster was also observed to be damaged close to this door. One room, currently used for staff

only, was found not to be maintained to an acceptable standard, and the inspectors observed this room to be untidy, with broken furniture also stored here. A broken cabinet was observed to be stored on the bedroom corridor of this unit.

There was sufficient communal space provided for residents in the centre. Two residents shared a bedroom and the inspectors identified issues relating to privacy and dignity for these residents which is addressed in Outcome 1.

While there were sufficient bathrooms available, issues were also identified with infection control precautions and are discussed in Outcome 7.

Not all aspects of the premises were reviewed as part of this inspection.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The inspectors found residents were not protected by infection control precautions in the centre. Residents had not been protected through incident and risk management procedures in the centre. Adequate fire management systems were not in place including emergency lighting, adequate means of escape and exit signage.

The inspectors found adequate infection control measures were not in place and residents in one unit did not have access to handsoap or hand drying facilities. An immediate action was issued to the director of care, acting on behalf of the provider. A response to this immediate action was given to inspectors outlining the measures the provider had taken to mitigate these risks. However, the inspectors, on attendance in this unit found these measures had not been implemented. There was no soap available in both resident bathroom areas and disposable handtowels provided in one bathroom were inappropriately stored. On attendance of the provider nominee, one aspect of this issue had been rectified in one bathroom, which was used by residents in this unit overnight. In addition, the inspectors found a resident was not provided with an opportunity to wash their hands prior to being served food, following exposure to unhygienic conditions. In another unit, where a potential infection control risks was identified, the inspectors found paper towels were inappropriately stored.

Damage was noted to a numbers of seat coverings in the centre, and the inspectors

were not assured given the profile of residents and their needs, that adequate infection control could be maintained. In addition, the inspectors noted a significant malodour in one bathroom as well as a build up of mould.

The inspectors reviewed risk management plans in the centre and found these plans did not guide practice. For example, one plan outlined that a specified medication should be administered in the event of a resident experiencing a seizure, however this was not consistent with the medication prescribed on the resident's prescription sheet. A number of risk management plans had incorrect information and the wrong residents' names, and the person in charge told inspectors these plans did not guide practice.

The inspectors found that some fire safety systems required improvement. In one unit, the exit route was blocked by furniture and household supplies and the inspectors requested these items be removed. This was completed at the time of instruction. There was no emergency lighting in four final exit routes in the centre and a number of exits were not clearly marked as fire exits.

The inspectors reviewed records of fire drills in one unit and found residents had been evacuated within a satisfactory timeframe. Suitable fire detection and fire fighting equipment was provided including fire alarms, fire extinguishers and fire blankets.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
The inspectors found appropriate measures had not been put in place in response to safeguarding concerns and there was an absence of the identification of safeguarding issues. Restrictive practices were inappropriately applied and appropriate assessments and support was not in place for some residents to support them with behavioural needs.

The inspectors found there was a lack of timely response to peer to peer safeguarding concerns. Peer to peer incidents were not appropriately reported to the relevant personnel at the time of occurrence in order to implement appropriate safeguarding measures to protect residents and in accordance with reporting requirements as per national guidelines. The provider had undertaken a review of incidents in the centre and safeguarding plans had been developed outlining the measures in place to alleviate immediate risks to residents in one unit. The inspectors found these measures were implemented on the day of inspection. However, the inspectors found the compatibility of residents, in particular in one unit remained an issue and impacted on residents' quality of life. The provider acknowledged this remained an issue and outlined funding had been approved for additional measures to mitigate some risks in this unit.

The inspectors observed a number of residents were engaged in inappropriate sexualised behaviour in communal areas in one unit however, there was a lack of response to protect both the residents engaged in the behaviour and peers in close proximity. There were no guidelines in place to guide the practice in supporting residents with this behaviour, or safeguarding plans to protect both these residents and their peers. In addition, residents were not safeguarded and supported with their intimate care needs in an appropriate and timely manner, and there was repeated incidents observed in a unit where residents requiring support presented in a state of undress in a communal area of the unit. While in one unit, staff responded to rectify the issue, the inspectors found measures were not in place to prevent these incidents in the first place. In a second unit, there was no response by staff to attempt to support a number of residents, observed with exposed lower body parts.

The inspectors found a number of restrictive practices in use which had not been assessed for use and resulted in residents not being able to access parts of their own home. The inspectors reviewed restrictive practice prescriptions in a unit and found a number of practices were not approved for use. This included locking of some internal doors and locking of presses. Staff outlined these were used due a lack of available staff supervision, and when there was sufficient staffing supervision available some of these doors were unlocked. The inspectors found that in these cases, the least restrictive measure for the shortest duration had not been applied and that alternatives had not been considered prior to the implementation of these practices. In another unit, the use of restrictive practices was applied despite any clear rationale for use.

For some restrictive practices, there were no up- to -date assessments which informed the risks and rationale for use of these practices.

The inspectors found there was no behaviour support plan or guidance to guide the practice in supporting a resident despite, a referral to request behaviour support being sent in September 2016.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

Findings:
The inspectors found the residents healthcare needs were not appropriately met by the care provided. There was a lack of knowledge on residents' healthcare needs and the supports required to meet those needs. An immediate action was issued on the morning of inspection to the provider nominee and a response was subsequently received from the provider outlining the measures taken to mitigate risks. Appropriate assessments and reviews by the relevant healthcare professionals were not completed in some cases and up-to-date plans were not in place in response to a changing need. Improvements were also required in the provision of food and nutrition to ensure residents' nutritional needs were safely and appropriately met.

On the morning of the inspection the inspectors found staff were not knowledgeable on residents' healthcare needs and of the support required to meet those needs. In addition, the guidelines for response to an emergency medical presentation were not available for staff and staff were not aware of the required response to this presentation. An immediate action was issued to the provider nominee on the morning of the inspection. The provider took measures to mitigate the risk by the end of the inspection. Further concerns were identified in a second unit in relation to staff knowledge of residents including their names and healthcare needs.

Residents were not consistently assessed or reviewed by the relevant allied healthcare professionals and the inspectors identified a number of outstanding referrals. For example, one resident had not been reviewed by a dietician following referral in August 2016 and residents with specific nutritional guidelines had not been reviewed by either a speech and language therapist or a dietician for two to three years. While one resident had an assessment for dementia in 2015, the person in charge was not able to clarify if this resident required a subsequent review or whether a review had been facilitated. Complete records were not maintained for a resident with specified nutritional intake requirements.

The inspectors found a resident's healthcare plan had not been updated following review and identified end of life needs.

The provider had undertaken a review of residents' healthcare needs in this centre and the inspectors reviewed these healthcare audits. These audits identified similar and additional concerns to the inspection findings including, a lack of up to date plans, plans not guiding practice, outstanding reviews required by allied healthcare professionals and interventions and outcomes not completed and recorded.

The inspectors observed a morning meal being served to residents and a main meal being served to residents in another unit. The inspectors were not assured that adequate choice was offered to residents. There was no evidence that residents were offered a choice at the time the morning meal was served and cereals were prepared and served on table prior to residents entering the dining room. Staff outlined that residents chose their preference the night before. Some residents were supported to pour their own drinks however, the inspectors found hot drinks were not appropriately prepared, and milk was already in teapots prior to serving. In the second unit, a resident was observed to be seated in the dining room and waiting 15 minutes to be served their meal. This resulted in the resident becoming distressed.

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):
No actions were required from the previous inspection.

Findings:
The inspectors found medication practices in the centre did not ensure residents were protected.

On the morning of inspection, the inspectors reviewed medication administration practices in the centre. One resident had not received medication as prescribed. The inspectors observed that this medication was pre-prepared and subsequently administered late to the resident. In addition, this resident had not received one medication and this was discussed with the nurse on duty who outlined that the usual practice was that this was administered by the night staff however, on this occasion, this had not been completed. An instruction was given by inspectors to the staff member to attend to this matter.

A review of medication prescription and corresponding PRN (medicines only taken as the need arises) protocols identified one medication protocol was in place however, this medication was no longer prescribed. In addition, the inspectors found where PRN medications (medicines only taken as the need arises) were prescribed for the same rationale, there were no guidelines available on the circumstances and decision making process for the administration of some of these medications. In addition, maximum dosage in 24 hours was not consistently stated in PRN (medicines only taken as the need arises) protocols.

Suitable medication storage was found to be in place in the centre. Some liquid medications were found not to have an opening date recorded.

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):
No actions were required from the previous inspection.

Findings:
The inspectors found the management systems in place had not ensured residents were safe and their needs were appropriately met. There was inadequate monitoring of the service, and reporting of issues of concern resulting in poor outcomes for residents in the centre. Reporting structures were not clear for staff.

The inspectors found the service provided was not safe and appropriate to residents needs, and major non compliances were identified in eight outcomes of the nine outcomes inspected against. Two immediate actions were issued on the day of inspection relating to infection control and healthcare needs. Poor infection control precautions were found and residents were not provided with appropriate handwashing facilities exposing them to a risk of healthcare associated infections. The provider had failed to ensure arrangements were in place to meet the assessed needs of residents in social care and in healthcare needs, impacting on the residents' quality of life and exposing them to risks. There was inadequate response to incidents and safeguarding concerns in the centre, and a failure on behalf of the provider to protect residents from harm. There was evidence of institutional practices in the centre and residents' privacy and dignity was significantly compromised. Residents were not protected by the medication management practices in the centre. The provider had not ensured a knowledgeable workforce at sufficient staffing level, was provided to meet the assessed needs of residents, and to ensure the care and support supported the dignity, privacy and rights of residents.

The inspectors found there was inadequate monitoring of the centre. Two unannounced visits in two separate units had been completed in the centre in 2016 and one more recently in one unit four weeks prior to the inspection. Unannounced visits completed in

2016, were found not to be a robust process. For example, in one unit, the review in May 2016, did specify that peer to peer incidents were occurring however, there was no follow up action arising from this review, to report this issue appropriately or to put measures to safeguard residents in place. In addition, the provider had recently developed risk registers for the centre however, on discussion with the person in charge it was not evident that an action to reduce the risk had been communicated to the person in charge in order to implement the stated control measure.

Staff were not clear on the day of inspection of the reporting structures and while staff did demonstrate that they tried to establish who the manager for that day was, a timely response was not provided.

The inspectors found the arrangement for the person in charge to manage two centres comprising ten units did not ensure the effective governance and operational management of this centre as evidenced in the non compliances identified on this inspection. The inspectors met with the person in charge on the afternoon of the inspection and discussed concerns and risks in the centre. The person in charge outlined their priority concerns for the centre however, was not able to demonstrate evidence that these concerns had been escalated to senior manager in order ensure appropriate action was taken. The inspectors also discussed the scope of the responsibilities with the person in charge however, in addition to managing the two designated centre, the person in charge provided an on call manager service for the campus comprising 26 units on a regular basis. For example, for in the preceding week, the person in charge had provided 24 hours on call cover however, this resulted in only 15 hours dedicated time to perform person in charge functions.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
The inspectors found there were insufficient staff numbers in accordance with the needs of residents. Continuity of care was not maintained resulting in exposure of residents to

risks, and impacting on their safety and wellbeing. Appropriate induction was not provided to staff, also resulting in a lack of knowledge of risk in the centre, residents' needs and fire safety procedures. Rosters were not consistently maintained reflecting the staff on duty.

On the morning of inspection, consistent staffing was not found. In one unit, there were three new staff of four, one of whom was assigned responsibility for the overall care of residents in the centre. These staff confirmed they did not know the needs of the residents and in one case, a staff did also not know the names of residents. There had been no information or induction provided to these staff members prior to commencing their shift and staff were not aware of residents' healthcare needs, social care goals, and fire procedures. In another unit, a staff member outlined it was their first day working in the unit, however, told the inspectors they had not been made aware of the risks in the unit, of the fire safety procedures or of the needs of the residents. In another unit, the inspector found a staff to whom the responsibility for the provision of care was assigned, was not sufficiently knowledgeable on residents' needs.

The inspectors reviewed staff rosters maintained in the centre. In some areas, units were frequently staffed below the specified levels and impacted on residents' needs, for example, social care needs. In addition, the inspectors found the specified quota of staffing in one unit of four staff was not in accordance with residents' assessed needs. For example, the staff outlined eight residents required 1:1 staffing to leave the unit, while additional levels of support were required for another resident. In addition, a recent safeguarding plan identified 1 of the 4 staff on duty was to be allocated to ensure the close supervision of a resident, however, there had been no increase in resources to reflect this change of need. The inspectors observed that appropriate care could not be provided to residents, due to staffing levels. There were a total of 3.69 staff vacancies on the day of inspection.

Rosters in one unit were found not be reflective of the staff on duty.

The inspectors identified that follow up training recommended as an action following a fire drill had not been provided to staff in one unit.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caroline Vahey
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Stewarts Care Limited
Centre ID:	OSV-0003899
Date of Inspection:	13 July 2017
Date of response:	05 October 2017

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:
The inspectors found there were institutional practices in the centre, impacting on residents' rights, dignity and quality of life.

1. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is

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

operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:
The level of staffing across the designated centres has been reviewed in line with the safeguarding, healthcare and other audits. Some initial changes have been made to increase the levels of staff support available. An additional 10 staff are deployed across Designated Centre 2 each day to ensure that sick and other leave can be covered.

Further to this a full review of the scope of the services provided and the level of resources and structures required to maintain the service is being undertaken. This work will be undertaken by an external consultant and will inform future developments. This will be completed by the end of October 2017.

A programme of training around understanding institutional practice will be undertaken by all staff.

Unannounced audits of practice are being undertaken.

Members of the service improvement team are working alongside staff to shape and guide good practice.

Proposed Timescale: 02/10/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' privacy and dignity was not maintained and was impacted by practices in the centre, a lack of appropriate support and a lack of suitable facilities. Residents' personal space and personal possessions were not protected.

2. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
In one unit where concerns had been raised in relation to the service provided, there was no evidence that this had been recorded as a complaint and as such actions taken to investigate and act on this concern.

3. 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:
The complaints officers are ensuring that issues raised are dealt with as the policy requires. The new induction of Persons in Charge includes managing and recognising complaints. The quality monitoring document set also includes an evaluation of compliance in relation to complaint management.

Proposed Timescale: 02/10/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements were not in place to meet the social care needs of residents and residents were not supported with meaningful activities on the day of inspection.

The compatibility of residents in one unit was identified as an issue impacting on the quality of life of residents.

Some staff were not aware of the social care goals of residents.

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

Please state the actions you have taken or are planning to take:
From the 20/7/17 additional supports have been put in place for nurses who may be moved to an unfamiliar area or who are engaged through an agency. A member of the nurse education team carries out a face to face induction and is available throughout the day to offer advice and support. This has already had a positive impact on practice.

The Director of Nursing has compiled a list of which areas each nurse is competent to work. This will show which nursing staff have received induction into which areas and will include an assessment of the competency of the nurse to work in a given area. This started on the 20/7/17.

An additional resource is now in place to ensure that when care staff are moved to new

or unfamiliar areas or are engaged through an agency. This started on the 20/7/17.

The level of staffing across the designated centres has been reviewed in line with the safeguarding, healthcare and other audits. Some initial changes have been made to increase the levels of staff support available. An additional 10 staff are deployed across Designated Centre 2 each day to ensure that sick and other leave can be covered.

Transition plans are in place for residents who need to move in the meantime safeguarding plans have been put in place to ensure that residents are safe.

The existing Designated Centre will be split into three new centres from the 4/9/17.

Each new Designated Centre will have its own Person in Charge.

This will allow the Person in Charge to effective manage the centre. The induction for the new Person in charge will commence on the 14/8/17

Personal plans are being rewritten in an easier to understand format and staff are being trained in writing personal plans.

All residents will have a Pathways to Independence programme which is aimed at assessing and then teaching the skills required for full participation is the tasks and activities of daily living. The Day Service staff will have responsibility for implementing the programmes under the direction of the Person In Charge.

Annual Pathway meetings are held for each resident. In this meeting goals are reviewed and set. These will be discussed during staff and house meetings. Progress in achieving goals will be monitored by the Person in Charge and this will be communicated to the Programme Manager by way of the compliance document set.

Proposed Timescale: 02/11/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Up-to-date social care plans were not in place for residents in one unit.

5. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
Personal plans are being rewritten in an easier to understand format and staff are being trained in writing personal plans.

Proposed Timescale: 02/10/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Aspects of one unit required improvement to ensure it was maintained to an acceptable standard and to ensure residents were not exposed to risks.

6. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
A planned programme of remedial maintenance work is now underway. A senior member of the local service improvement team is responsible of liaising with the technical services to ensure that the programme is fully implemented.

Proposed Timescale: 02/10/2017

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:
Risk management plans were not reflective of the practice in the centre.

7. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Incidents were not appropriately reported or followed up in a timely manner in order to mitigate risks to residents.

8. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
A new system of risk management has been introduced. Risk registers in relation to healthcare and safeguarding have been introduced. A new fulltime admin assistant has been employed to manage the risk registers and to ensure they are up to date. The risk registers are stored on a shared drive and all relevant staff have access to it. This started on the 28/6/17.

Twice weekly triage meetings are held between the Director of Care - Residents, the Director of Nursing and the Risk manager. All incidents are reviewed and actions taken are checked for implementation. Any learning is noted and then reported to the relevant Person in Charge to ensure action is taken. This started on the 28/6/17.

All risks rated as high are reviewed daily in the MDT Care Planning meeting. This started on the 28/6/17.

An MDT approach is being taken with the safeguarding and healthcare risk registers, each clinician has responsibility for the risk ratings within their area of expertise. This has commenced.

All incident reports are now uploaded onto SURA to allow for easier access and monitoring. This started on the 28/6/17.

Proposed Timescale: 11/08/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not provided with hand soap or handtowels in order to ensure safe hand washing techniques.

Appropriate support was not provided to a resident in relation to hand washing.

Paper towels were not appropriately stored where a potential infection control risk was suspected.

Furnishings were not kept in a good state of repair in order to ensure adequate infection control precautions.

9. 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:
A planned programme of remedial maintenance work is now underway including the repair and replacement of furnishing and furniture. A senior member of the local service improvement team is responsible of liaising with the technical services to ensure that the programme is fully implemented.

Soap and hand towels are now in place.

Paper towels are appropriately stored.

Residents are supported with hand washing. This is also an element of the Pathways to Independence Programme.

Furnishing are being replaced or repaired as required. The Person In Charge is responsible for checking furnishings for wear and tear.

Proposed Timescale: 15/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The exit route in one unit was blocked by furniture and household supplies.

There was no emergency lighting in four final exit routes.

A number of fire exit routes were not marked

10. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
A planned programme of remedial maintenance work is now underway including emergency lighting and signage. A senior member of the local service improvement team is responsible of liaising with the technical services to ensure that the programme is fully implemented.

The fire exit is no longer blocked and the staff in the area have been reminded of the importance of keeping all exits clear.

Exit routes will be marked and have appropriate safety lighting installed.

Proposed Timescale: 02/11/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some restrictive practices were not assessed for use. Restrictive practices were applied at times due to a lack of available staff supervision.

11. 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:
Measures have been put in place to ensure restrictive practices are applied in accordance with the assessed needs of residents, and their use is appropriately applied and monitored.

All areas have been audited in line with best practice and the HIQA Guidance document to ensure that all existing restrictive measures in use have been implemented in line with the regulations and best practice. This now complete.

Examination of environment and practice to identify the use of any unauthorised restrictive measures has been undertaken. A number of restrictive measures that where not previously detected as such have been identified and appropriate plans put in place. Support has been sought from the appropriate clinicians in respect to this. The restrictive measures policy is also being rewritten as a stand-alone document instead of a part of the managing Behaviour Policy This is now complete with the exception of the new policy which is awaiting approval.

Enhanced monitoring of restrictive measures through the new compliance document set will increase oversight and understanding. This will allow for the effectiveness and necessity of measures to be monitored and evaluated .This will start on the 14/8/17.

The protocols and other guidance in relation to the use of PRN medication has not always been clear. This is being addressed with new protocols being put in place where necessary. The protocols are being written in such a way that they clearly guide practice. This will be completed by the 14/8/17.

Proposed Timescale: 18/09/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not supported with some observed behaviours of concern.

The least restrictive measures for the shortest duration was not implemented in the application of some restrictive practices. Alternative measures were not consistently considered prior to restrictive practices being implemented.

There was no behaviour support plan in place for a resident following a referral for behavioural support in September 2016.

12. 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:
Measures have been put in place to ensure restrictive practices are applied in accordance with the assessed needs of residents, and their use is appropriately applied and monitored.

All areas have been audited in line with best practice and the HIQA Guidance document to ensure that all existing restrictive measures in use have been implemented in line with the regulations and best practice. This now complete.

Examination of environment and practice to identify the use of any unauthorised restrictive measures has been undertaken. A number of restrictive measures that where not previously detected as such have been identified and appropriate plans put in place. Support has been sought from the appropriate clinicians in respect to this. The restrictive measures policy is also being rewritten as a stand-alone document instead of a part of the managing Behaviour Policy This is now complete with the exception of the new policy which is awaiting approval.

Enhanced monitoring of restrictive measures through the new compliance document set will increase oversight and understanding. This will allow for the effectiveness and necessity of measures to be monitored and evaluated .This will start on the 14/8/17.

The protocols and other guidance in relation to the use of PRN medication has not always been clear. This is being addressed with new protocols being put in place where necessary. The protocols are being written in such a way that they clearly guide practice. This will be completed by the 14/8/17.

All residents have been assessed using The Harris Challenging Behaviour Scale, this has allowed for focused supports to be put in place to support any behavioural concerns. Behaviour support plans are being put in place as required by the Psychology Department and a CNS Positive Behaviour Support has recently been appointed to support this work.

A new process for reviewing restrictive measures has been put in place by the CEO. This is includes oversight by a Rights Committee which has an independent external chairperson.

The new process includes consideration of all alternative less restrictive measures in each case.

The Person In Charge has received additional safeguarding training which has included the use of restrictive measures. The use of all restrictive measures is logged and regularly reviewed by the Person In Charge.

Proposed Timescale: 18/11/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents had not been protected from incidents of peer to peer abuse. Safeguarding concerns had not been identified as such and responded to in a timely and appropriate manner in order to protect residents from harm.

Safeguarding concerns had not been reported to the appropriate personnel in accordance with required national guidelines.

Safeguarding concerns were not identified as such and there were no safeguarding plan in place to protect some residents.

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:
The following measures have been put in place to ensure residents are protected from abuse and to ensure systems identify and allow appropriate responses to risks in order to ensure residents are protected from abuse.

Safeguarding concerns are reported to both the HSE safeguarding team and HIQA in line with national guidelines. The HSE safeguarding team has met regularly with the Principal Social Worker with responsibility for safeguarding.

A clear structure for reporting and responding to safeguarding concerns has been put in place by the Principal Social Worker with responsibility for safeguarding. This structure is supported by 25 staff who are trained as designated officers.

All resident records have been audited by the local service improvement team to determine if any safeguarding issues have been unreported and/or inappropriately managed. This is now complete.

Safeguarding risk assessments have been completed for all residents who were highlighted as being at risk by the Person in Charge. Safeguarding plans have been implemented as required. This has led to a reduction in the number of negative peer to peer incidents with no further incidents reported from those deemed to be presenting

the highest level of risk. It has also highlighted that some residents are inappropriately placed and transition plans have been put in place as required. Three residents cannot be safely managed within their current accommodation and alternative accommodation has been sourced and these residents will move by mid-August (subject to registration and successful consultation with the residents and their families). Some groups of residents within particular units are incompatible and additional staff resources are required to fully implement safety plans.

Three individual apartments are being constructed to allow for the residents who are causing difficulties for others to be safely managed. These apartments will be stand alone with their own staff team and Person in Charge. This will allow for residents to be supported with the appropriate levels of staff until a transition to a permanent, alternative placement can be organised. This measure will safeguard both the individuals who are moved and those who were previously at risk of harm.

The risk assessments have been entered into the safeguarding risk register by the Director of Care - Residents. This has allowed for areas of priority to be identified across the service. Key risks include; the use of unapproved restrictive measures, incompatible peer groups, staff that are unfamiliar with residents needs and in some areas insufficient staff to meet the needs of residents.

The safeguarding risk register is now monitored daily by the Director of Care - Residents and the effectiveness of safety plans is assessed and changes made as required. Residents who require urgent intervention are identified at the 9.00am MDT Care Planning meeting and resources are deployed accordingly. This commenced on the 28/6/17.

The Safeguarding Risk Register is the responsibility of the Director of Care - Residents until the 3/8/17 when a new Principal Social Worker with responsibility for safeguarding commences in post. Daily reports are also made to the CEO of any areas of high risk. The new Social Worker commences on the 3/8/17.

Any internal notification of suspected abuse must be accompanied with an immediate safety plan which sets out what actions frontline staff have taken to ensure safety. This is a change from existing practice where the Designated Officer completed the safety plan. This has proved to be very effective and emphasised to frontline staff that safeguarding is the responsibility of everyone and has allowed for a much quicker response This commenced on the 28/7/17.

No new care or treatment plans will be implemented until the author has ensured that all staff are aware of the plan and are clear on how the plan should be implemented. This has led to a change in practice and ensured that safeguarding measures are consistently applied. This is being introduced on a phased basis and commenced on the 3/7/17.

Proposed Timescale: 11/08/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not supported with their personal intimate care needs in order to protect their dignity and bodily integrity.

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

Please state the actions you have taken or are planning to take:
No new care or treatment plans will be implemented until the author has ensured that all staff are aware of the plan and are clear on how the plan should be implemented. This has led to a change in practice and ensured that safeguarding measures are consistently applied. This is being introduced on a phased basis and commenced on the 3/7/17

Staff are being retrained in the provision of intimate care and supports.

Proposed Timescale: 02/10/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate healthcare was not provided to residents. There was a lack of staff knowledge of residents' healthcare needs and the supports required to meet those needs.

There was no guidance available on the response to an emergency medical presentation and staff were not aware of the response to be implemented.

Complete records were not maintained for a resident with specified nutritional intake requirements

15. 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:
From the 20/7/17 additional supports have been put in place. A member of the nurse education team carries out a face to face instruction and is available throughout the day to offer advice and support. This has already had a positive impact on practice.

The Director of Nursing has compiled a list of which areas each nurse is competent to work. This will show which nursing staff have received induction and training into which areas and will include an assessment of the competency of the nurse to work in a given area. This started on the 20/7/17.

An additional resource is now in place to ensure that care staff are appropriately trained , supported in responding to emergency health situations.

Performance management plans are in place for a number of staff who have been detected as lacking skills and competence which they would be expected to have.

Nutritional and fluid records are maintained for all residents on SURA. These records are checked by the Person in Charge to ensure that the resident's needs are being met. In the event of a specific concern an individual's care plan and recording system may be put in place.

Regular checks are kept on changes in weight and BMI to ensure that adequate nutrition is being provided.

Proposed Timescale: 02/10/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not facilitated with required reviews by allied healthcare professionals in accordance with their needs.

16. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
A programme of annual reviews has been put in place for all residents.

A new process for assessing the urgency of any required intervention. This involves the use of a risk rating system . Daily meetings between the Director of Nursing and the Head of Clinical Services to highlight urgent cases.

Proposed Timescale: 11/08/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident's healthcare plan had not been updated following review and identified end

of life needs.

17. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
All healthcare have been audited. Action plans to remedy any gaps highlighted, these actions plans have been passed to the Person in Charge for implementation.

Proposed Timescale: 30/08/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Hot drinks were not appropriately served.

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

Please state the actions you have taken or are planning to take:
An audit of mealtimes has taken place across all of the homes within the designated centre by the service improvement team.

The local service improvement team is now working alongside staff members to assist in the development of good practice. The initial focus is to increase the competence and knowledge of the nursing staff. This started on the 28/6/17.

Proposed Timescale: 11/08/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident was not served their meal in a timely manner resulting in a negative experience for this resident.

19. Action Required:
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:
An audit of mealtimes has taken place across all of the homes within the designated

centre by the service improvement team.

The level of staffing across the designated centres has been reviewed in line with the safeguarding, healthcare and other audits. Some initial changes have been made to increase the levels of staff support available. An additional 10 staff are deployed across the Designated Centre each day to ensure that sick and other leave can be covered.

The local service improvement team is now working alongside staff members to assist in the development of good practice. The initial focus is to increase the competence and knowledge of the nursing staff and care staff. This started on the 28/6/17.

Sufficient staffing resources will be deployed at mealtimes to ensure that residents can be served with the minimum of waiting times. The Person in Charge has ensured that staff rosters ensure that maximum staff levels are maintained during mealtimes.

Proposed Timescale: 02/10/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Adequate choice was not offered to residents at a mealtime.

20. Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
An audit of mealtimes has taken place across all of the homes within the designated centre by the service improvement team. Issues identified as requiring action have been responded to.

The local service improvement team is now working alongside staff members to assist in the development of good practice. The initial focus is to increase the competence and knowledge of the nursing staff. This started on the 28/6/17.

Proposed Timescale: 11/08/2017

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:
Liquid medication did not consistently have opening dates recorded.

21. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
Liquid medication will have the opening date recorded and regular medication audits take place to monitor this.

Proposed Timescale: 11/08/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medications were not administered as prescribed.

A PRN (as required) protocol for a resident, was not evidently prescribed for this resident.

Maximum dosage in 24 hours was not consistently stated in PRN (as required) protocols.

There were no guidelines available on the circumstances and decision making process for the administration of some PRN (as required) medications.

22. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

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:
The arrangement for the person in charge to manage two designated centres comprising ten units did not ensure the effective governance and operational management of the centre.

23. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
The existing Designated Centre will be split into three new centres from the 4/9/17.

Each new Designated Centre will have its own Person in Charge.

A two week programme of induction and handover commences on the 14/8/17.

Proposed Timescale: 04/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Lines of accountability and reporting were not clear on the day of inspection.

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

Please state the actions you have taken or are planning to take:
The existing Designated Centre will be split into three new centres from the 4/9/17.

Each new Designated Centre will have its own Person in Charge.

The Director of Care - Residential meets with members of the Service Improvement Team and key MDT staff at 9.00am each morning to review risk registers and staffing deployment. Priorities are identified and resources deployed as appropriate under the clear direction of the Director of Care.

Proposed Timescale: 04/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management system in place had not ensured the service provided was safe and appropriate to residents' needs. The service was not monitored regularly or appropriately and where issues were identified, corrective action was not taken to

mitigate risks to residents.

Evidence was not available to confirm issues of concern had been escalated by the person in charge to senior manager in order to ensure appropriate action to mitigate risks was taken.

25. 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 new system of risk management has been introduced. Risk registers in relation to healthcare and safeguarding have been introduced. A new fulltime admin assistant has been employed to manage the risk registers and to ensure they are up to date. The risk registers are stored on a shared drive and all relevant staff have access to it. This started on the 28/6/17.

Twice weekly triage meetings are held between the Director of Care - Residents, the Director of Nursing and the Risk Manager. All incidents are reviewed and actions taken are checked for implementation. Any learning is noted and then reported to the relevant Person in Charge to ensure action is taken. This started on the 28/6/17.

All risks rated as high are reviewed daily in the MDT Care Planning meeting. This started on the 28/6/17.

An MDT approach is being taken with the safeguarding and healthcare risk registers, each clinician has responsibility for the risk ratings within their area of expertise. This has commenced.

All incident reports are now uploaded onto SURA to allow for easier access and monitoring. This started on the 28/6/17.

Proposed Timescale: 11/08/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Unannounced visits by the provider were not completed at six monthly intervals.

Unannounced visits did not consider all areas of the centre as part of this review.

Remedial action was not taken to risks identified during unannounced visits.

26. 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:
Unannounced visits commenced on the 16/6/17 and a schedule is now in place to ensure that the six monthly timescales are met.

At the end of the visit a detailed action plan is put in place, this is written by the auditor and the Person in Charge.

Progress on completion of implementation of the action plan is tracked by the Director of Care in the fortnightly Care Management meeting.

Any high risk issues identified are addressed immediately.

Proposed Timescale: 04/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements for the person in charge to provide on call support to 26 units on a regular basis was not appropriate and impacted on their capacity as person in charge of this designated centre.

27. 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:
The existing Designated Centre will be split into three new centres from the 4/9/17.

Each new Designated Centre will have its own Person in Charge.

A system of On Call support is being introduced from the 4/9/17, the On Call responses will be made by a dedicated team which does not include the Persons in Charge.

Proposed Timescale: 04/09/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

the following respect:
Sufficient staffing levels were not provided in accordance with required levels, and the assessed needs of residents.

28. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Additional staff resources have been made available to ensure that sufficient support is maintained. Up to 10 additional staff are available to be deployed each day. This ensures that sickness and other leave can be covered.

Safeguarding and other plans indicate where additional staff resources are required.

A recruitment campaign has been successful in reducing staff vacancies and will continue to ensure that posts are filled.

Proposed Timescale: 11/08/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Continuity of care was not maintained resulting in exposure of residents to risks, and impacting on their safety and wellbeing.

29. 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:
A weekly meeting is held with the Director of Care and the three programme managers. Staff deployment is confirmed this includes ensuring that staff are prepared and skilled to work in the area that they are assigned to.

Proposed Timescale: 04/09/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Rosters in one unit were found not be reflective of the staff on duty.

30. 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:
A weekly meeting is held with the Director of Care and the three programme managers. Rosters are confirmed for the week ahead and the previous rosters are signed off as being accurate.

Proposed Timescale: 11/08/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not been provided with induction training, resulting in reduced outcomes for residents.

Training had not been provided following a recommendation as an outcome to a fire drill.

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

Please state the actions you have taken or are planning to take:
From the 20/7/17 additional supports have been put in place for nurses who may be moved to an unfamiliar area or who are engaged through an agency. A member of the nurse education team carries out a face to face induction and is available throughout the day to offer advice and support. This has already had a positive impact on practice.

The Director of Nursing has compiled a list of which areas each nurse is competent to work. This will show which nursing staff have received induction into which areas and will include an assessment of the competency of the nurse to work in a given area. This started on the 20/7/17

An additional resource is now in place to ensure that when care staff are moved to new or unfamiliar areas or are engaged through an agency. This started on the 20/7/17.

Performance management plans are in place for a number of staff who have been detected as lacking skills and competence which they would be expected to have. This has commenced.

The competency matrix will ensure that staff will only be deployed to areas in which they are deemed competent and this will include training in relation to the fire procedure.

Twice weekly triage meetings are held between the Director of Care - Residents, the

Director of Nursing and the Risk Manager. All incidents including fire drills are reviewed and actions taken are checked for implementation. Any learning is noted and then reported to the relevant Person in Charge to ensure action is taken. This started on the 28/6/17.
Proposed Timescale: 11/08/2017