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 5
Centre ID:	OSV-0003902
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stewarts Care Limited
Lead inspector:	Thomas Hogan
Support inspector(s):	Conor Brady
Type of inspection	Unannounced
Number of residents on the date of inspection:	29
Number of vacancies on the date of inspection:	3

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:
19 October 2017 07:00	19 October 2017 15:54

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 to assess the designated centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was conducted as part of the provider's assessment of application to renew the registration of this designated centre. It was the Health Information and Quality Authority's (HIQA) fourth inspection of this designated centre and it was completed over one day. At the time of the last inspection (19 July 2017) inspectors found all nine outcomes inspected against to be in major non-compliance with the Regulations. As a result of the concerns found at the time of that inspection, notices of proposal to cancel the registration and refuse the renewal of registration of the designated centre were issued. A representation was submitted to HIQA by the registered provider following the issuing of the notices of proposal and the assurances outlined in this document formed a core element of this inspection process.

Description of the service:
The service provider had produced a statement of purpose which outlined the service provided within this designated centre. The centre was based in a large campus based setting in Dublin and was comprised of four detached buildings which provided

residential services to 29 persons with disabilities at the time of inspection.

How we gathered our evidence:
The inspector met with 14 of the residents availing of the services of the centre and spoke in detail with four residents. The inspector also spoke with seven staff members, the person in charge, the programme manager, and the director of care. Various sources of documentation, which included the statement of purpose, residents' files, centre self-monitoring records, policies and procedures, risk assessments etc., were reviewed as part of this inspection. Additionally, in assessing the quality of care and support provided to residents, the inspector spent time observing staff engagement and interactions with residents. Also a full walkthrough of the centre was completed by the inspector in the company of the person in charge.

Overall judgment of our findings:
Nine outcomes were inspected against as part of this inspection and overall the inspector observed a very high level of regulatory non-compliance. All nine outcomes were found to be in major non-compliance with the Regulations. 25 of the 28 actions from the previous inspection were found not to have been satisfactorily implemented.

These findings, along with further details, can be found in the body of the report and accompanying action plan.

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, respected or maintained in the designated centre. There remained evidence of institutional type practices in place. Five actions from the previous report were found to have not been satisfactorily implemented.

The person in charge confirmed that independent advocacy services had not been sought for any resident of the designated centre since the time of the last inspection.

In one unit of the designated centre two residents remained sharing a modest sized bedroom which contained no privacy screens or curtains. In another unit inspectors found that maintenance works had commenced to adapt a bedroom with ensuite facilities into a bedroom and main bathroom. The staff member on duty highlighted that this change would provide another resident, who previously had no access to a main bathroom or shower room, to now have access without entering another resident's bedroom. Inspectors found, however, that at the time of inspection the resident had to enter the other resident's bedroom to access the light switch for the new main bathroom and shower room. In a separate area of the designated centre inspectors found a bathroom area with two steel toilets in place. One toilet had a door in place, however, the second toilet only had a plastic shower curtain in place to maintain the privacy and dignity of residents.

Inspectors found that satisfactory action had not been taken since the last inspection relating to the use of steroidal antiandrogen medication for two residents. A review of

the residents' files found that in the case of one resident there was no review of the use of the steroidal antiandrogen medication since the last inspection by mental health professionals, the multidisciplinary team or the restriction meeting forum. In the case of the second resident, an entry in the mental health notes made very brief reference to behaviours of a sexualised nature, however, the impact of the use of the steroidal antiandrogen was not considered. Similarly to the case of the first resident, no review of the use of this medication had taken place by the multidisciplinary team or the restriction meeting fourm since the time of the last inspection.

At the time of the last inspection it was found that there were no risk assessments relating to the use of steroidal antiandrogen medication available. In addition there was an absence of consent, evidence of consultation with the residents or family members, or independent advocacy services relating to this matter on the file of either resident. This remained the findings at the time of this inspection. Inspectors remained concerned with regards to the welfare and rights of both residents for whom this medication was prescribed.

The person in charge outlined that a business case for additional staffing resources had been made which would allow for an opportunity to address the concerns relating to the use of steroidal antiandrogen medication in the designated centre. Inspectors reviewed this document and found that it briefly mentioned that chemical restraint was in use for both residents, however, it did not suggest any formalised proposal for the discontinuation of same. In addition, the person in charge confirmed that no response to the submission of the business case had been received from the senior management team of the organisation. No other evidence of action in relation to this matter was made available to the inspector.

Inspectors found that a resident was not satisfied with the outcome of a complaint made regarding environmental and compatibility issues in one unit of the designated centre. While the complaints procedures were found to be on display in the centre, inspectors identified that measures were required for the improvement in the area of responses to complaints made.

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 appropriate and meaningful social care in accordance with their needs.

All three of the actions from the previous report relating to social care needs were found not to have been satisfactorily implemented.

Assessments of need completed in the designated centre took the format of a 'dependency assessment framework' and examined the areas of self-care, risk, independence, and health. It was not clear who completed the assessments and if there was multidisciplinary team involvement in this process. No assessments of social care or personal needs were completed for residents. Assessments of the health, personal and social care needs of residents were found not to have been completed on at least an annual basis.

Personal plans were in place in some for some of the assessed needs of residents, however, there was no evidence of review of plans for their effectiveness available. From the evidence made available to inspectors it was found that there was an absence of multidisciplinary input in development of personal plans.

Inspectors observed that residents in the designated centre were spending prolonged periods of unoccupied time in living rooms and bedrooms. Overall it was found that there was a lack of opportunity for meaningful activities for residents. 'Meaningful activity records' of a sample of residents were reviewed by inspectors.

Activities were found to be mainly campus based in nature and in the case of one resident there were only five occasions documented in a one month period of non campus based activities. In the case of another resident there were only two non campus based activities recorded for the same period, one of which was a bus drive. The only entry made on one day of two residents' meaningful activity records were "fire evacuation this am due to toaster overheating, music therapy while staff meeting was held this pm also".

Staff members spoken with at the time of inspection highlighted the availability of transport vehicles as a barrier to achieving social care goals for residents. A system in place in the wider campus based services of sharing a limited number of transport vehicles was found to be very restrictive by inspectors. The availability of vehicles was not planned and examples of events being cancelled at short notice due to vehicle inability were outlined to the inspector.

The person in charge outlined that there was difficulty with access to the multidisciplinary team in the designated centre. He explained that there was a waiting list of approximately two years for psychology inputs at the time of inspection.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Overall, the inspectors found that the design and layout of the designated centre was not suitable for its stated purpose and meeting the individual and collective needs of residents in a comfortable and homely way.

Actions from the previous inspection relating to safe and suitable premises were found to not have been satisfactorily implemented.

The centre did not provide sufficient accommodation to meet the needs of residents. Space was limited in bedrooms and did not allow for unrestricted movement. Two residents were sharing a bedroom of limited size and no additional privacy measures had been taken since the time of the last inspection.

There were inadequate showering and bathing facilities in the centre. In one area six residents used one toilet and one shower and in another area five residents used one shower. In one unit there were steel toilets in place and no toilet seats. While there were hand washing facilities available to residents, there was no hand soap in place and hand towels were stored openly on a wet floor without packaging. In addition, there were no waste facilities available for the disposal of used hand towels. This matter was brought to the attention of the person in charge and representative of the registered provider at the time of the last inspection.

While areas of dampness in one unit of the designated centre were found to have been rectified, extensive remedial works remained outstanding in two units. In these areas there was extensive chipping of paint from walls and requirements to repaint rooms throughout. This matter was also brought to the attention of the person in charge and representative of the registered provider at the time of the last inspection.

In another area of the designated centre inspectors found that remedial works which

had been undertaken to address the lack of a bathroom and shower room being available for one resident, was found not to be satisfactorily addressing the previous non-compliance with the Regulations identified. One resident previously had to enter the bedroom of another resident to access toileting and showering facilities. Since the time of the last inspection a dividing wall had been installed in the resident's bedroom to covert his ensuite facilities into a main/shared toilet and shower room. Inspectors found, however, that the light switch for the new main toilet and shower room remained in the resident's bedroom and therefore anyone using these facilities had to access to bedroom to turn on the light.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The inspectors found that the health and safety of residents was not maintained, promoted and protected in the designated centre. Significant concerns identified at the time of the last inspection were found to not to have been satisfactorily addressed. In addition, further significant concerns relating to the areas of management of risk, incident and accident management, and the adequate precautions in the risk of fire were identified at the time of this inspection.

The clear and substantial absence of arrangements for the identification, investigation and learning from serious incidents which resulted in poor outcomes for residents and exposing residents to serious risk of injury and harm which had been identified at the time of the last inspection had not been satisfactorily addressed. Inspectors found that in the time since the last inspection six incidents in one unit of the designated centre were not appropriately followed up on. In another unit, inspectors found one incident had not been followed up on appropriately. The person in charge confirmed that appropriate action had not been taken in all cases.

At the time of the last inspection fire fighting equipment in one area of the designated centre was found to not have been serviced since 2014. This matter was brought to the attention of the person in charge and representative of the registered provider at that time. When this equipment was checked by inspectors at the time of this inspection it was found that these two pieces of equipment remained not serviced since November 2014.

Serious concerns were found in the area of fire protection. In one unit of the designated centre it was found that a fire drill which reflected true staffing and resident ratios had not been completed since April 2013. While fire drills had been completed in this area in the intervening time period, these had either a reduced resident number present or an increased staffing number present. Only 46.7 per cent of staff members employed in the designated centre were found to have participated in a fire drill.

In another area of the designated centre it was found that there was one staff member on duty overnight with minimal supports available for limited periods from a second staff member. There were 11 individuals residing in this unit and a review of personal emergency egress plans (PEEP) for these residents found that all 11 individuals required supports. One individual required evacuation with the assistance of two staff members using an emergency 'ski sheet' while another individual was found to have a visual impairment. Another resident was described as having a profound hearing impairment, while another individual required close one-to-one supervision during an evacuation. When a staff member on duty in this area overnight was asked whether the unit could be evacuated safely in the event of a fire, they responded by stating it was not possible. Inspectors found that this staff member had never participated in a simulated fire drill within this unit.

Another member of the staff team spoken with, who was employed during day hours on the day of inspection, stated that they were not confident that all residents could be evacuated from the unit in the event of a fire. The inspector found that this staff member had never participated in a fire drill of any kind in the unit.

A review of staff training records found that 22.2 per cent of staff members had not completed fire training in line with the organisation's requirement.

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 that residents had not been protected against abuse in the designated centre. There remained concerns regarding the lack of knowledge and recognition of what constituted abuse and the actions required to be taken in the event of witnessing or suspecting abuse. Serious concerns remained regarding the lack of appropriate response to safeguarding incidents in the designated centre. The person in charge confirmed that all incidents of a safeguarding nature which had occurred in the centre had not been responded to in accordance with the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (Health Service Executive, 2014).

A review of incident and accident reports relating to two areas of the designated centre found that six incidents of abuse had not been appropriately followed up on in line with the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (Health Service Executive, 2014). Three of these incidents related to peer to peer physical abuse, two incidents related to unexplained bruising observed on residents, and one related to a peer to peer verbal abuse incident. When a senior member of the staff team spoken with was asked about the appropriate response to unexplained bruising, they stated that addressing incidents of that nature did not always involve safeguarding considerations.

Inspectors spoke with five staff members about what constituted abuse and the appropriate actions to take in the event of witnessing or suspecting abuse of a resident. Two staff members demonstrated appropriate knowledge of these areas. When asked if those spoken with could identify who the safeguarding designated officer for the service was only two staff members correctly identified the person holding this position.

A review of staff training records found that only 13.3 per cent of staff members employed in the designated centre had completed training in 'safeguarding vulnerable persons awareness programme'. When clarification was sought, a training officer confirmed that this programme was deemed a mandatory training requirement for all staff.

The person in charge outlined that in one area of the designated centre only two of ten residents requiring positive behavioural support plans had these in place. In the cases of both residents inspectors found that the plans had not been reviewed in the timeframe identified as being required on the documents.

In another area of the service a positive behaviour support plan in place for a resident was found not to sufficiently guide the practice of staff. It was not clear what actions to take if the nine brief guidelines provided in the plan were found to be ineffective. A review of the plan had not taken place in the timeframe identified on the document as being required.

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 inspectors found that residents' healthcare needs were not appropriately or safely met on the day of inspection.

In one area of the designated centre, where 11 residents were living, inspectors met with a staff member who was working alone on night duty with minimal supports available for limited periods from a second staff member. Inspectors found that four of the residents availing of the services of this unit had a medical history which included epilepsy. When asked about the health care plans in place for these residents, and what actions to take in the event of seizure activity, the staff member stated that an ambulance would be called for after five minutes. When inspectors asked about seeking assistance from staff in other areas of the service, the staff member indicated that they would not and instead stated that requesting an ambulance was the action he would take. The health care plans in place relating to epilepsy for two of the residents required emergency medication to be administered after three minutes of seizure activity. When this was brought to the attention of the staff member by inspectors they confirmed that they had not previously been aware of this matter.

A review of daily nutritional and fluid intake records of two residents was completed by inspectors. In the case of one resident, records for the day prior to the inspection stated that the resident had no fluid or nutritional intake between 10:44 hours and 16:36 hours (a period of 5 hours and 49 minutes). The total fluid intake for the day was recorded at just 1400mls. In the case of another resident, there were only two small meals recorded for the 24 hour period. There was no nutritional or fluid intake between 09:48 hours and 18:10 hours (a period of 10 hours and 22 minutes). The total fluid intake for the day was recorded as being 1150mls. A staff member spoken with by inspectors confirmed that this was a true reflection of intake for both residents. This matter was brought to the attention of the person in charge, the programme manager, and the director of care at the time of inspection.

Health care plans in place in the designated centre were found not to sufficiently guide staff practice. In addition, inspectors found that plans were not reviewed on at least an annual basis and where if there was multidisciplinary inputs available for reviewing plans. A health care plan in place for one resident with epilepsy did not outline how the individual presented when experiencing seizure activity or how staff were to manage that health care need. In another case, a health care plan in place relating to

hypercholesterolemia was found to have had no entries made since October 2016.

The meal time experience for breakfast and lunch in the designated centre was observed by inspectors. This was found to be a very stressful and unpleasant experience for residents and institutionalised practices were observed. The environment was noted to have been very loud and staff assisting residents with eating and drinking were observed to issue instructions to other residents on a continuous basis. Inspectors found that there were not sufficient numbers of staff members available to assist residents during the mealtimes observed. White personal protective equipment plastic aprons, normally used by staff during intimate care practices in the designated centre, were used for each resident. The criteria for use of the plastic aprons was not clear even after the inspector spoke with the person in charge about this practice.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

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

The administration of medication for two residents in one area of the designated centre was observed by inspectors to be outside of the prescribed timeframe. Medication included in those administered outside of the prescribed timeframe included those used for the management of epilepsy.

PRN medication (medication only taken as the need arises) protocols were found not to be in place for one medication. In another case, where a PRN protocol was in place, inspectors found that there was conflicting guidelines regarding the criteria for administration in two separate sections of the protocol.

The person in charge confirmed that no risk assessments or capacity assessments had been completed regarding the self administration of medication by residents in the designated centre.

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

Findings:
The inspectors found that effective management systems were not in place in the designated centre to support and promote the delivery of safe, quality care to residents. It was found that the provider had continued to fail to provide a safe and reliable service in which residents' needs were appropriately met and protected from abuse. In addition, it was found that there was inadequate monitoring of the service taking place.

Inspectors found that one of the four units comprising the designated centre had a six monthly unannounced visit completed by the registered provider, or a person nominated by the registered provider. This was completed on 18 September 2017. A report summarising the unannounced visit was made available to inspectors. It was found that the person carrying out the unannounced visit did not consult with residents, their relatives or representatives as part of the visit. Several serious errors were noted within this report including the lack of recognition of complaints and the incorrect provision of information relation to allegations of abuse and notifiable incidents. A review of the action plan arising from the unannounced visit found that the majority of actions had not been completed in the timeframe set out. In addition, inspectors found that the unannounced visit process failed to identify serious concerns which present ongoing risk to residents.

In the case of the remaining three units of the designated centre no evidence of completion of unannounced six monthly visits by the registered provider, or person nominated by the registered provider were made available to inspectors.

Inspectors was informed that the designated centre was in the process of reconfiguration and, in the time since the last inspection, additional persons in charge had been appointed. Notification of these appointments had not been made to HIQA, however, and on the day of inspection the arrangements for the governance and management of the designated centre remained unclear for residents, staff members

and managers spoken with. The manager who identified themselves as the person in charge, and had been employed as a person participating in management in the previous configuration of the designated centre, outlined the current arrangements to inspectors. It was found that arrangements in place were not satisfactory and did not provide for adequate governance and management of the centre.

While the person in charge was identified as having responsibility for one area of the reconfigured designated centre, they also had an additional on-call responsibility for the entire campus service which involved a large proportion of time being dedicated to managing issues not related to the designated centre. In addition, the person in charge was unable to outline what arrangements were in place during their absences which, due to the rostering arrangements of the designated centre, could be as many as eight days per fortnight.

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 that the number and skill mix of staff on duty in the designated centre at the time of inspection was not appropriate to the number and assessed needs of residents. Staff were not sufficiently knowledgeable of residents' needs and support requirements. Appropriate supervision arrangements were found not to be in place.

In one area of the designated centre inspectors found that one staff member was working alone for extended periods of a night shift while providing care to 11 residents. The staff member identified that they were unable to evacuate residents to a place of safety in the event of a fire. Supports in place for the staff member involved a second staff member who was shared across other units of the campus services. A record of the second staff member's presence in the unit was reviewed by inspectors and it was found that it was only partially completed and did not clearly outline the total time spent in the area by the staff member.

Inspectors was not assured by the level of experience of staff and found that there was an overreliance on the use of agency staff within the designated centre. Staff members in two areas of the designated centre spoken with by inspectors highlighted the use of agency staff had an impact on continuity of care for residents. The staff members spoken with also informed inspectors that staffing numbers dropped below the minimum required numbers in the designated centre on occasions.

Staff training records for mandatory courses were reviewed by inspectors and it was found that none of the ten mandatory categories had been completed by all staff members. Two categories were found to have only 13.3 per cent of staff training completed.

Arrangements for the supervision of staff were found to not have been satisfactory by inspectors. The person in charge was unable to outline the supervision arrangements in place for times when they were not present in the designated centre. From a review of staff rosters, it was found that the person in charge could be absent for up to eight days in a 14 day period. This was as a result of rostering arrangements in place. Formal supervision records were not reviewed as part of this inspection.

A sample of staff files were reviewed and it was found that overall they contained the required documents as outlined in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, in the case of one staff file reviewed, it was found that the dates on which employment commenced and ceased was not present.

The person in charge confirmed that no volunteers were employed in the designated centre.

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:

Thomas Hogan
Inspector of Social Services
Regulation Directorate

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Stewarts Care Limited
Centre ID:	OSV-0003902
Date of Inspection:	19 October 2017
Date of response:	18 January 2018

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. One resident did not have access to a lit bathroom or shower room and had to access another resident's bedroom to access the light switch for these facilities.

2. Two residents were sharing a bedroom which was limited in space and did not promote the privacy or dignity of either individual.

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

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

Please state the actions you have taken or are planning to take:
Bathroom and shower room has been reconfigured and a new communal bathroom has been fitted which has full access and lighting facilities for both residents. Transition plans have been put in place to ensure that both residents have their own bedrooms.

Proposed Timescale: 30/03/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was unclear if two residents participated in and consented to decisions about their care and support in relation to the administration of steroidal antiandrogen medication. The rationale and review process regarding this practice was not available at the time of inspection.

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

Please state the actions you have taken or are planning to take:
a) A full audit of records has taken place to ensure that the rationale and review process regarding the aforementioned practice is evident. This information will be available for future inspections.
b) Family consultation scheduled for Friday 12/01/18.
d) The person in charge has referred both residents to advocacy services to ensure their care and support are in accordance with their wishes.
e) The advocacy service has visited some houses within the designated centre to give information about their service and further visits are organised through the Person in Charge.

Proposed Timescale: 17/01/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that residents had access to advocacy service and information

about their rights.

3. Action Required:
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

Please state the actions you have taken or are planning to take:
a) An audit was carried out identifying any resident who required advocacy services who was not accessing them and referrals have been submitted.
b) The advocacy service has visited some houses within the designated centre to give information about their service and further visits are organised through the Person in Charge.
c) Residents are educated about their right to advocacy during weekly meetings where resident's rights are discussed.

Proposed Timescale: 17/01/2018

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Complete records of complaints, including investigation into, actions taken and whether or not the resident was satisfied were not maintained in the designated centre.

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

Please state the actions you have taken or are planning to take:
The Complaints Policy is being reviewed which includes mechanism for local recording of records of complaints, including investigation into, actions taken and whether or not the resident was satisfied.

Proposed Timescale: 22/01/2018

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:
Residents' personal plans were not reviewed annually or more frequently where there was a change in needs or circumstances.

5. Action Required:

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

Please state the actions you have taken or are planning to take:
There is review of the personal plans currently underway. Plans shall be reviewed and updated annually or more frequently where required.

Proposed Timescale: 28/02/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident was not carried out as required to reflect changes in need and circumstance on at least an annual basis.

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

Please state the actions you have taken or are planning to take:
An audit tool has been implemented that will identify the residents that do not have a comprehensive assessment of needs. Where it is identified that one is required or due for review, one will be carried out.

Proposed Timescale: 28/02/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that there was a lack of opportunity for meaningful activities for residents.

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

Please state the actions you have taken or are planning to take:
a) Activities are planned with the residents during weekly residents meetings and monthly keyworker meetings.
b) Additional opportunities have been identified to encourage residents have opportunities for meaningful activities. Opportunities include access to a range of activities in the gym, including sound yoga, motor skills group, mindfulness, etc. The

person responsible for the programmes has presented at a PIC meeting on the 22/12/17.
c) Residents are encouraged to try such new activities, recording wills and preferences.

Proposed Timescale: 28/02/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Bathroom facilities were found not to be of a suitable standard to meet the needs of residents.

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

Please state the actions you have taken or are planning to take:
Bathroom and shower room has been reconfigured and a new communal bathroom has been fitted which has full access and lighting facilities for both residents.

Proposed Timescale: 05/01/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Paint work required attention throughout two areas of the designated centre.

9. 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:
The action plan submitted by the provider did not satisfactorily address the failing identified.

Proposed Timescale:

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:
There was a clear and substantial absence of arrangements for the identification, investigation and learning from serious incidents resulting in poor outcomes for residents and exposing residents to ongoing serious risk of injury and harm.

10. 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) The policy shall be reviewed so to include arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.
b) Incidents are reviewed for learning purposes within the house.
c) Risk is a standing item at the PIC Programme Manager.
d) The Risk Committee is a board subcommittee and presents directly to the board on a quarterly basis.
e) A risk report is presented to each Executive Management Team by the Risk Manager on a quarterly basis.

Proposed Timescale: 28/02/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. One staff member had never completed a fire drill in the unit of the designated centre that they were employed in.

2. A staff member working night duty alone for periods of the night in a unit of the designated centre which was home to 11 residents had never completed a night time fire drill in the unit.

3. In one unit of the designated centre a fire drill had not been completed with a realistic staff and resident ratio since 2013.

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

Please state the actions you have taken or are planning to take:
All staff are currently undergoing area specific refresher fire safety training.
Deep sleep fire drills have been completed and night duty fire safety training is underway. Personal Evacuation plans have been reviewed to ensure they reflect the needs of the residents.

Proposed Timescale: 31/01/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A review of staff training records found that only 46.7 per cent of staff members had completed fire training in line with the organisation's requirement.

12. 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:
All staff are currently undergoing area specific fire safety training. All staff are required to undergo fire safety training including the use of extinguishers on a regular basis. An audit is underway to identify where staff have not attended training and this will be actioned.

Proposed Timescale: 28/02/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Fire fighting equipment in one unit of the designated centre was found not to have been serviced since November 2014.

13. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
All firefighting equipment has been serviced in Dec 17.

Proposed Timescale: 18/01/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. Positive behaviour support plans were found not to be in place for eight residents

who were identified by the person in charge as requiring same.

2. In the case of three residents who had positive behaviour support plans in place, these were found not to have been reviewed as part of a personal planning process or within timeframes identified on individual documents.

14. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
a) A priority list for Behaviour Support Plans has been developed using The Harris Scale- where residents were identified as in need of urgent behavioural support, this has been provided.
b) The Multi-Disciplinary Review of resident's plans is currently underway.
c) Until the development of behaviour support plans is complete, interim guidelines shall be developed to guide staff practice.
d) Behaviour Support Plans shall be reviewed by the person in charge.

Proposed Timescale: 30/06/2018

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Incidents of potential abuse were not identified as safeguarding concerns and as such were not reported or managed appropriately in line with the national policy. As a result adequate measures were not in place within the designated centre to ensure that residents were safeguarded against abuse.

15. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
a) Going forward the service will respond to allegations of abuse in line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policies and Procedures.
b) All areas have will have an identified Designated Officer for reporting incidents or allegations of abuse.
c) All allegations of abuse will be reported to a Designated Officer.
d) Incidents will be screened and reported to the HSE in line with Policy.
e) All incidents will result in a safeguarding plan with a review date. Where additional resources are identified within a safeguarding plan, these will be provided.
f) Weekly NIMs to be reported by PIC to PM, to assess effectiveness of Safeguarding Plans. Evidence to CEO

Proposed Timescale: 31/01/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
86.7 per cent of staff were found not to have mandatory training in 'safeguarding vulnerable persons awareness programme' completed.

16. 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:
a) An audit was carried out to identify which staff have no evidence of receiving safeguarding training.
b) These staff have been scheduled to attend the training to ensure that all staff have received training in safeguarding.
c) There is a service wide campaign put in place to ensure all staff are trained in the HSE Raising Safeguarding Awareness for Vulnerable Persons. Weekly training sessions have been scheduled accommodating 30 staff members. All staff have been scheduled to attend over the coming months.

Proposed Timescale: 30/06/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Incidents of potential abuse were not investigated.

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

Please state the actions you have taken or are planning to take:
a) Going forward the service will respond to allegations of abuse in line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policies and Procedures.
b) All areas will have an identified Designated Officer for reporting incidents or allegations of abuse.
c) All allegations of abuse will be reported to Designated Officer.
d) Incidents will be screened and reported to the HSE in line with Policy.
e) All incidents will result in a safeguarding plan with a review date. Where additional resources are identified within a safeguarding plan, these are provided.
f) Weekly NIMs to be reported by PIC to PM, to assess effectiveness of Safeguarding Plans. Evidence to CEO.
g) Incidents will be reviewed by the PM at regular visits to the house to ensure they are

all incidents of potential abuse are reported and investigated.

Proposed Timescale: 31/01/2018

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:
Inspectors were not assured that there was sufficient input and review of the healthcare needs of residents by allied health professionals.

18. 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) Access to allied health professionals is identified in assessment of need. A review of the assessment of need for residents shall be carried out.
b) Where a need is identified, access shall be provided.

Proposed Timescale: 30/03/2018

Theme: Health and Development

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A staff member providing care to 11 residents in one unit of the designated centre was found not to be knowledgeable of the recommendations outlined in the healthcare plans and as a result increased risks for four residents.

19. 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:
All staff are being assessed on their knowledge and understanding of needs and plans and where gaps are identified, training will be provided.

Proposed Timescale: 30/06/2018

Theme: Health and Development

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

in the following respect:
Inspectors found that there were not sufficient numbers of staff present to assist residents during mealtimes observed.

20. 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:
The action plan submitted by the provider did not satisfactorily address the failing identified.

Proposed Timescale:

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident was found to have had no nutritional or fluid intake in a 10 hour and 22 minute period on the day prior to inspection. This resident had a recorded total fluid intake of 1150mls in a 24 hour period. Another resident was found not to have any nutritional or fluid intake for a 5 hour and 49 minute period on the same day. This resident had a total recorded fluid intake of 1400mls in a 24 hour period.

21. Action Required:
Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

Please state the actions you have taken or are planning to take:
The recording format for fluid and food has changed to a hard copy with the aim of easier completion for staff and more accurate recordings. A review of the health care needs of the residents has confirmed that there are no residents at risk of dehydration. Where there is concerns about a resident's weight, they are monitored closely by the Director of Nursing, or a designated individual.

Proposed Timescale: 18/01/2018

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:
1. Medications were observed to have been administered to two residents outside of their prescribed timeframe.

2. There was no PRN (medication only taken as the need arises) protocol in place for one PRN medication.

3. A PRN protocol in place for a medication was found to be contradictory in the criteria provided for administration of the medication in two separate sections of the protocol.

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

Please state the actions you have taken or are planning to take:
a) The medication policy has been reviewed to provide clear direction on the procedures for ordering, receipt, prescribing, storing, disposal and administration of medication.
b) All kardexes are being reviewed to ensure they are in place, up to date and reflect a person centred time for the administration of medication.
c) Protocols are being reviewed to ensure they provide clear direction to staff.
d) All nurses are being assessed as to their competency in administering medication.

Proposed Timescale: 31/03/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector found that risk assessments and assessments of capacity were not completed for residents regarding the self administration of medication.

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

Please state the actions you have taken or are planning to take:
Residents will be assessed for their capacity to self-administer and risk assessment will be completed identifying the support required.

Proposed Timescale: 30/03/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:
1. The management systems in place in the designate centre had not ensured that the service provided was safe in particular in relation to safeguarding, healthcare, health and safety and risk management, medication management and fire safety.

2.The management systems in place in the designated centre had not ensured that the service provided was appropriate to residents' needs particularly in relation to upholding the rights and dignity of residents and appropriate supports in response to behaviours which may challenge.

3. The services provided and systems in place in the designated centre were not appropriately monitored. Issues of concern were not identified or acted upon,

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

Please state the actions you have taken or are planning to take:
a) The structure of the designated centre has been reconfigured to increase the number of Persons in Charge from 1 to 4. There is a recruitment drive underway to recruit the remaining vacancy.
b) All PICs are required to appoint shift leaders in the absence of the Person in Charge. The Shift Leader reports to the Programme Manager.
c) A schedule of audits have been implemented to provide oversight to ensure the effective monitoring of services.
d) Weekly reports to the Programme Manager provide oversight to the management of the centre.
e) Regular visits from the Programme Managers to carry out announced audits

Proposed Timescale: 28/02/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Clearly defined management structures were found not to be in place in the designated centre.

25. 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:
All PICs are required to appoint shift leaders in the absence of the Person in Charge. The Shift Leader reports to the Programme Manager. A schedule of audits have been

implemented to provide oversight to ensure the effective monitoring of services.

Proposed Timescale: 22/01/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to carry out an unannounced inspection to all areas comprising of the designated centre at least once every six moths 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.

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:
A schedule of unannounced visits has been put in place for all areas comprising of the designated centre at least once every six months and a written report shall be prepared on the safety and quality of care and support provided in the centre and a plan put in place to address any concerns regarding the standard of care and support.

Proposed Timescale: 18/01/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that there was a significant reliance on agency staff within the designated centre which did not ensure that residents received continuity of care and support.

27. 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) All agency staff are inducted by the person in charge or shift leader.
b) Persons in charge are currently undergoing training to manage their own rosters.
c) The Director of Care has issued a directive that commencing 22/01/17 no staff may

be moved from their designated centre without approval from the Programme Manager.
d) Agency booking is being managed through the Workforce Planning Office to ensure agency staff are assigned to familiar areas.

Proposed Timescale: 30/03/2018

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that the number of staff was appropriate to the number and assessed needs of residents in the designated centre.

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

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

Proposed Timescale:

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that all ten categories of mandatory training within the centre was not completed for all staff members.

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

Please state the actions you have taken or are planning to take:
a) An audit of staff training is currently underway.
b) All mandatory training will be completed within the designated centre.

Proposed Timescale: 30/06/2018

Theme: Responsive Workforce

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

Inspectors found that staff were not appropriately supervised in the designated centre.

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

Please state the actions you have taken or are planning to take:
a) The structure of the designated centre has been reconfigured to increase the number of Persons in Charge from 1 to 4. There is a recruitment drive underway to recruit the remaining vacancy.
b) PICS are now located within their area of responsibility
c) All PICs are required to appoint shift leaders in the absence of the Person in Charge. The Shift Leader reports to the Programme Manager.
d) A schedule of audits have been implemented to provide oversight to ensure the effective monitoring of services.
e) Weekly reports to the Programme Manager provide oversight to the management of the centre.
f) Regular visits have been scheduled by the Programme Managers to carry out announced audits

Proposed Timescale: 28/02/2018