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:	No 3 Fuchsia Drive
Centre ID:	OSV-0005139
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Ireland
Lead inspector:	Thelma O'Neill
Support inspector(s):	Liam Strahan
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration 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:
31 August 2018 09:00	31 August 2018 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was the fourth inspection of this centre carried out by the Health Information and Quality Authority (HIQA). The last inspection took place on 18th July 2018 in response to an application by the provider to register this centre; however, due to the level of serious non-compliances identified during that inspection, three urgent actions and 24 regulatory breaches were issued to the provider, the most serious related to fire safety management, safeguarding and safety and workforce. This inspection was conducted to review the actions taken by the provider since the last inspection and to inform a registration decision for this centre.

How we gather our evidence:
As part of the inspection, inspectors met with residents residing in the centre, the director of services, sector manager, the newly appointed team leader, staff members and the person in charge of the centre. Inspectors spoke with the residents, staff and management team and reviewed documents maintained in the

centre.

Description of the service:
The centre was located in a village and approximately 25kms from Cork city. The design and layout of the centre was in line with the centre's statement of purpose. The centre was a domestic single-storey bungalow with a small garden to the front and back and an apartment to the rear of the house.

The house comprised of four bedrooms for residents, including one bedroom for sleepover staff and a separate apartment that accommodated one resident. Residents accessed services in their local community, and were well known in the local area. Interactions between staff and residents were supportive and appropriate and inspectors saw that the residents were very happy and staff were kind to the residents. Some residents chose to show inspectors their bedrooms or apartment, which were suitably decorated and personalised.

Inspection findings:
Inspectors found that although some improvements had occurred in the centre, in relation to documentation, communication assessments and visiting arrangements, the provider had failed to adequately address the three urgent actions and the 24 regulatory breaches found on the last inspection. Many of these breaches had previously been identified on the inspections in 2017 and 2014 and were still not complete. The most serious of these issues related to fire safety management, safeguarding, managing behaviour of concern, risks management, workforce and governance and management.

On the day of inspection, staff and the team leader could not provide the required information to evidence the actions taken to address the urgent actions from the last inspection and the senior managers were contacted by inspectors to provide the evidence to inspectors. However, the provider and management team could not provide evidence to demonstrate that sufficient actions had been taken to address the serious risks and non compliances identified on the last inspection. Although, the provider had strengthened the governance structure by appointing a new team leader to the centre, the provider and management team did not demonstrate effective lines of accountability or responsibility in relation to oversight and management of the centre. They also failed to ensure that the necessary resources were in place to support the effective delivery of quality care and support to people using this service. The provider also failed to ensure that the organisations policies and procedures were effectively implemented in the centre to ensure the centre was run effectively in line with the statement of purpose.

In addition, inspectors found that there were no effective quality assurance mechanisms in place to audit practices to ensure service delivery was meeting the required standards and regulations. The annual and six-monthly provider-led audits did not identify or evaluate the risks in the centre. For example, the senior managers of the service were not aware that the staffing allocation for social activities had not been increased following failings identified on the last inspection or that fire doors in the centre did not meet the fire safety regulations until this was brought to their attention by the inspectors on the day of this inspection.

Although the registered provider's representative gave inspectors assurances following the last inspection that that the three urgent actions and regulatory failings would be addressed, inspectors found they were not addressed. Inspectors found that there was no arrangements in place to adequately support a resident with behaviour of concern. Furthermore, there had been no increase in social support staff in the centre and in fact the staff support situation had deteriorated since the last inspection. Inspectors also found the provider did not complete the actions required to ensure fire safety equipment and procedures met regulatory requirements or that there were robust risk management procedures in place to identify, review and manage risks in the centre. Safeguarding plans were not in place to ensure all staff were aware of residents individual support requirements and the provider was continuing to investigate the inappropriate use of residents money identified on the last inspection, In addition, notifications had not been submitted as required, despite assurances that notifications would be submitted retrospectively following the last inspection and the residents' service level agreement had not been amended within the providers own agreed timelines.

Inspectors alerted the PPIMs and the person in charge on the day of inspection of their failure to take sufficient action to address the urgent risks in the centre. The PPIM told inspectors that they would submit further information to HIQA following the inspection with updates in relation to fire safety and the status of one of the resident's placement in the centre. Although, information was received from the PPIM, post this inspection, inspectors found the provider had not ensured that the fire alarm system had been serviced following it's failure to work properly on the last inspection in July, and to ensure it was operating in proper working order.

The managers also failed to provide assurances that the two fire evacuation plans were reviewed and one effective plan put in place following the inspection. As a result of these lack of assurances, inspectors found the information received was not sufficient to ensure the centre was meeting regulatory requirements.

Consequently, due to sustained levels of non compliance since 2014, and the failure to respond to urgent actions following the previous inspection, a decision has been made following the inspection to issue a notice of proposal to refuse and cancel the registration of this centre to the provider the Brothers of Charity.

Findings of the inspection are detailed in the body of the report and should be read in conjunction with the actions outlined 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
This outcome was found to be substantially compliant in July 2018, with two actions arising; supporting one resident to access advocacy service and increased opportunities for one resident to access the community.

Records demonstrated that staff had explained to residents the role and purpose of external advocacy services. This was undertaken through an easy-to-read guide on advocacy. Residents indicated to inspectors that if they wished to access advocacy they would ask a staff member to help them contact the external advocate. Telephone records also demonstrated that management had contacted an external advocacy service to establish how they may set up a structured contact with the advocacy service.

With regards to increased community access the resident in question informed inspectors that they were happy with their activation level. Since the last inspection this resident had been supported with increased activities, such as the introduction of art therapy. However, inspectors found residents' access to the community was time limited.

A sample of daily logs were reviewed. These indicated that residents were accessing the community for activities such as concerts, car trips, family visits and meals out. Activity records also showed that visitors were welcomed into their home and that residents were supported to visit each other where residents had separate living accommodation.

Arrangements regarding resident meetings, religious services, complaints and personal possessions were not reviewed on this occasion as these were found to be compliant in

July 2018.

Judgment:
Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Following the previous inspection an action arouse in relation to the need for communication assessments by appropriate health professionals.

Since the previous inspection, communications assessment from a suitably allied health care professional had been completed. This had resulted in a number of changes within the centre through the structured introduction of picture boards and social stories. Processes were also in place for the utilisation of easy-to-read information, the centre having recently obtained easy-to-read information on behavioural support. Similarly, records of daily activities showed that easy-to-read information on advocacy had been shared with residents.

A sample of personal planning documents was reviewed. These included residents' communication needs, preferences and abilities; as well as the appropriate interventions. Observations showed that staff interactions with residents reflected these communication needs and supported interventions. This included staff knowledge of non-verbal communication such as facial expression and gestures.

Protocols in relation to peer-to-peer interaction had been in place at the time of the last inspection. These continued to be implemented.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
This outcome was found to be substantially compliant in July 2018; inspectors found that although service level agreements were in place in the centre for all residents, not all agreements specified the level of care and support provided in the centre, or the full details of the services provided and fees to be charged.

On this inspection, the provider representative showed evidence they were working on this issue, but they had not achieved their own timeline to have this action completed by the 31/8/18.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
In July 2018 three actions had arisen in relation to this outcome. The first related to updating of resident social care plans. The second action related to implementation of supports around social care, behaviour management, transitional planning and staffing resources. The third action related to following up on referrals.

Resident files had been updated and contained personal communication passports detailing residents' likes/dislikes and hobbies, as well as preferences relating to activities, communication and meals. They also contained a description of residents and

an outline of their medical needs. Additionally management had implemented a tracker to monitor referrals. Inspectors were informed that this overview would guide monitoring of all referrals going forward.

The second action remained open; this related to assessing social care supports and staff supports requirements. With regards to transitional planning supports inspectors found no paperwork in the centre for a resident who had recently transitioned into long-term respite.

An assessment of residents positive behavioural support plans showed one resident required support to manage their behaviours of concern; however, they did not have an assessment or a plan in place. The provider discussed with inspectors the plan for a member of staff to be trained in the creation of these.

A sample of daily activity logs indicated that residents were facilitated to access a range of social activities through day and residential services. Logs also reflected that replacement assistive equipment had been ordered for one resident to better meet their mobility needs.

Inspectors found that residents' health and social and emotional well-being were sensitively supported by staff and that residents' individual needs and preferences were respected by staff. Nevertheless improvements were required in relation to the individual health assessments and plans to support residents access the community in the evenings, behavioural supports assessments, staffing and transitional assessments in order to comply with the requirements of regulation.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors found that the location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely way. There were appropriate facilities in place and the layout of the centre promoted residents' interests, independence and wellbeing.

The centre consists of a single storey house, which was suitably furnished and fitted for occupancy by three residents. To the rear of the house was an apartment designed, furnished and laid out for one resident. Each resident had their own bedroom, two of which were en-suite. However, one resident's en-suite was deemed to be too small for the resident's individual needs; however, there were plans to expand the ensuite for the resident to make it more accessible. The apartment had a kitchen/sitting room, while the house had a sitting room and large kitchen diner. In the main house the bathroom was an accessible wet room. Storage within the house was limited, with a mop and bucket being stored within the shower of one en-suite. Some aspects of the centre required general maintenance such as a broken lamp and paintwork on the attic access.

Since the last inspection the premises had been subject to an environmental audit by an occupational therapist and the provider's facility staff. This audit had resulted in an action plan to increase the premise' accessibility to residents. This was of particular importance for outdoor areas, which the provider was intending to change the layout of the gardens. One example of this was that there were plans for greater use of the front garden; however, access to this was across gravel which was a potential risk to any resident with mobility needs. Consequently the provider was implementing site improvement works to include a ramp, patio area and railings. These works were scheduled to begin the week following inspection.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
Inspectors found the provider had not addressed the urgent actions identified on the last inspection in relation to fire safety management. In addition, the provider assurance plan submitted to HIQA in response to the last inspection was not complete. Also, operational and individual risk management procedures were found to be non-compliant; as all risks in the centre were not identified, managed and escalated to the senior management team as per the organisational risk management policy. Storage restrictions also create infection control issues in the centre.

On the last inspection fire safety management was a major concern, and inspectors issued an urgent action to the provider on three grounds:

1) to ensure arrangements were put in place to test fire equipment
2) to ensure the provider made adequate arrangements for staff to receive suitable fire training and awareness of fire procedures. 3) to ensure staff and residents were aware of, and participated in fire safety drills.

The provider could not demonstrate to the inspectors that any of these urgent actions had been fully completed.

On the last inspection, inspectors found fire alarm and call points system in the apartment were not working properly and had to be repaired. Inspectors were given assurances by the person in charge that the alarm would be serviced by a competent fire alarm engineer immediately after the inspection; however, it was not serviced and no tests had been conducted on the fire alarm system to check if the call points were now working properly. Inspectors also found there were no intumescent strips (smoke seals) or door closures on the fire doors in the house and there were large gaps in the fire doors affecting the integrity of the fire doors, which would allow smoke to pass through the doors. This risk was brought to the attention of the PPIM's on the day of inspection.

The provider had arranged for two days of bespoke fire safety training for all staff to be held in the centre; however, inspectors found three staff working in the centre had not received the training and one sleepover relief staff member working alone on the day of inspection had not participated in fire drills in the centre. This was a concern as inspectors found staff members on duty were not aware of the fire risks identified since the last inspection. Furthermore, the provider failed to review fire safety procedures and practices in the centre and ensure that there was an effective evacuation plan in place and that staff working in the centre were familiar with the fire plan. For example, inspectors found there were two evacuation plans in use in the centre and neither plan provided accurate information on the layout of the centre, or the number of residents residing in the centre. Furthermore, the fire exits identified on the floor plans had not been updated since the apartment was renovated and staff were not aware if the floor plans reflected this.

These issues were brought to the attention of the provider representative who acknowledged the urgent actions and other regulatory actions had not yet been completed within the timelines. The senior manager did arrange for the fire officer to review the fire equipment and fire safety measures in the centre within 5 days and they would submit a fire report assessment to HIQA. However, while a fire report was submitted post inspection, it failed to provide assurances that all of the fire risks identified on inspection had been addressed, or that a plan was in place to address the risks.

Inspectors reviewed the organisational specific risks in the centre; for example, environmental risks, staffing resource issues, safeguarding risk and found they were not identified on the centre risk register. However, this was addressed by the managers on the day of inspection.

The inspector reviewed the management of individual risks in the centre and found that although individual risks assessments had improved since the last inspection, they failed

to complete a comprehensive assessments of risks for all residents; for example, Inspectors identified two residents were frequently being left unattended when staff were supporting another resident in the apartment in the morning and evening. The residents left unattended had histories of having un-witnessed falls and one resident was also diagnosed with epilepsy.

The provider failed to review the frequency and level of risks in this centre. Previously inspectors were told by the person in charge that she could not access the organisations risk management data in the centre and consequently, could not accurately analyse the level of risks reported in the centre, as accident and incident records were not available for review. These risks were not identified in the annual review or the six-monthly provider led audits of the centre.

Inspectors reviewed the management of infection control in the centre and found that infectious control practices were not in line with good practice guidelines as a mop and bucket was stored in a resident's en-suite shower.

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:
Inspectors found that although the provider had implemented a visitor's protocol since the last inspection, there continued to be inadequate safeguarding procedures in place in the centre. For example, not all staff had undertaken up-to-date safeguarding training. There were environmental restrictions in place, as part of a safeguarding decision and the investigation into the inappropriate use of resident's money was still under review since the last inspection.

Over the last few inspections, the provider and person in charge had failed to ensure appropriate safeguarding procedures were in place in the centre. The inspectors found that despite safeguarding risks in the centre, the residents' safeguarding plans were

closed and HSE safeguarding team was incorrectly advised that one resident was no longer living in the centre. Inspectors issued an urgent action to the provider to review their safeguarding procedures during the previous inspection; however, on this inspection, inspectors found although a restrictive protocol were put in place for the resident living in the apartment regarding visiting the main house, safeguarding plans were not reinstated and HSE safeguarding team were not informed that the resident was living in the centre and had access to the other residents.

Residents told inspectors that they would like to have access to use their back garden; however, there was an environmental restriction in place as a safeguarding measure, but it was not identified as such, and was not reported as required to HIQA on the quarterly returns.

Furthermore, on the last two inspections, inspectors reviewed that management of behaviours of concern and found that the person in charge had not ensured that a resident who required positive behaviour support had a support plan in place. Inspectors found that the resident living in the apartment had recently displayed aggressive and threatening behaviour towards a staff member, and although the resident had a history of this, the provider had failed to complete a positive behaviour support assessment to identify any additional support residents and staff may require in order to feel safe in the centre.

Following the last inspection, the provider commenced an investigation into the inappropriate use of residents' money to pay for services and items normally provided for by the organisation. This included the payment for staff support for residents to attend social activities and for some food items. At the time of this inspection, the provider was still investigating this issue.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
At the time of the previous inspection a number of incidents had not been notified to the Office of the Chief Inspector. The provider proposed to submit these retrospectively by 31 August 2018. On this date it was agreed with the regulator that this timeframe could be extended to 04 September 2018 due to extenuating circumstances. This subsequent

deadline was not met.

Inspectors reviewed incident reports and resident's records and were satisfied that notifications (for the period since the previous inspection) had been submitted to the chief inspector, as required by Regulation 31.

The provider and the person in charge demonstrated they were aware of their legal responsibilities to notify the Chief Inspector as and when required.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
In July 2018 this outcome was found to be substantially compliant, with one action arising. This action required that health care plans and information be updated. This action had been completed.

In addition records indicated that residents had access to a range of allied health care professionals. Since the last inspection residents had accessed the occupational therapist, speech and language therapist, physiotherapist psychologist and psychiatrist. The team leader had also introduced an overview matrix to track progress on referrals. This was particularly important as some referrals had long periods between a referral and an appointment due to waiting lists.

Inspectors found that arrangements were in place to ensure residents' nutritional needs were met. However, inspectors found that one resident was identified as at risk of choking when eating, however, a feeding, eating and drinking assessment (FEDS)had not been completed to determine the risk of choking to the resident; particularly when the resident had unsupervised access to food in their apartment.

Some of the recommendations from allied health professionals had resulted in planned premises-works within the centre. Additionally plans were in place to introduce picture menus. These changes would further enhance the quality of life for residents.

Judgment:

Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall, inspectors found the provider failed to ensure there was effective governance structures in place, with clear lines of accountability, and that all members of the management team were aware of their responsibility to manage an responsive service.

On this follow up inspection the persons participating in the management of the centre (PPIM's) did not demonstrate that there was systems in place to monitor the care and support needs of residents, the delivery of quality services and the implementation of action plans as required. They did not ensure that necessary resources were in place to support the effective delivery of the quality of care and support to people using the service and to implement policies and procedures to ensure the centre was run effectively.

Furthermore, inspectors found the provider had not assured themselves that the urgent actions identified on the last inspection were addressed and that residents living in this centre were safe and were adequately supported to achieve a good quality life.

During the inspection, inspectors found that the provider had not demonstrated that they had an awareness of the risks and that they had complete oversight of the service delivery in the centre. Although the person in charge confirmed that she was regularly present in the centre, they could not satisfactorily demonstrate the work undertaken to address the actions issued on the last inspection.

The provider had not ensured that the urgent actions issued in relation to fire safety management, safeguarding or staffing had been addressed and the persons participating in the management (PPIMs) failed to verify if actions had been implemented. For example, they did not ensure that fire equipment in operation in the centre was effective and met regulatory standards. Furthermore, they failed to ensure that safeguarding plans were implemented to so that all staff members were aware of safeguarding concerns and the need for visiting protocols and environmental restrictions

in the centre. Furthermore, the person in charge failed to ensure that there was appropriate staffing in the centre, to supervise residents in the centre and to ensure the residents had opportunities to have choice to make decisions about their social activities in the evenings.

The person in charge was appointed to this role in April 2018 and was initially appointed to mange five designated centres; however, the provider has since reduced this to four centres. A new team leader was also appointed to support the person in charge manage the centre who was present on the day of inspection and provided inspectors with available documentation; however, she was not aware of the actions required to address the urgent issues following the last inspection.

Overall, inspectors found the provider and the PPIM failed to ensure that the staff and service was effectively supervised and managed and that the urgent action and regulatory breaches had been addressed; as outlined in previous action plan responses. They also failed to demonstrate that progress was been made in all of the areas requiring improvement, or that they had an effective plan in place to bring this centre back into compliance. The provider had consistently failed to ensure effective oversight of the centre; for example, there had been no provider-led audits completed since the last inspection and PPIM's failed to ensure that verbal assurances they had received were accurate.

The annual review completed post the last inspection did not reflect the issues identified in the last inspection report or identify actions to improve the risks. In particular how staffing resource are utilised, that appropriate safeguarding procedures were in place in line with organisational policies and procedures, the suitability and compatibility of residents living in the centre or currently on respite or that fire safety and risk management procedures were appropriate to meet residents needs.

Judgment:
Non Compliant - Major

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
Inspectors found on the last inspection there were a number of areas where the provider did not demonstrate that they had sufficient resources to meet the assessed needs of residents. In particular, one resident was moved to a respite centre in April

2018 for additional medical and staffing support and a supervision assessment - due to his medical practitioner requesting a transfer due to the current level of support in the centre not being sufficient to meet his needs.

Following the urgent action issued on the last inspection, the provider had submitted an action plan response stating that resource allocation had be reviewed and appropriate staff resources would be implemented; however, inspectors found staffing resources in the centre continued to be inadequate to support the needs of individual residents social and recreational activities.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found that there was no effective response to the urgent action which was issued on workforce following the last inspection. On this inspection, inspectors found the staffing needs had increased due to risk management concerns and there was a lack of response from the provider to implement required staff resources. Inspectors also found that staff had not received the required staff training and development and that there was appropriate supervision in place to oversee the serious breaches in regulatory requirements identified on previous inspections.

On this inspection, inspectors found residents both in the house and in the apartment were being left unattended, despite evidence that this was a risk, and there was no effective plan in place to mitigate these risks. Inspectors were also told that one of the residents in the centre had been readmitted to a congregated setting "for respite" as it was found by their clinicians the current level of staffing support in the centre was insufficient to meet his health and social care needs. However, there was no evidence to show what staffing resources or supports had been introduced to support the resident within the centre prior to the decision readmit the resident back to a congregated setting.

Inspectors reviewed the response to the urgent action issued on the previous inspection. Although, the provider had given HIQA assurances that the staff roster would be reviewed immediately and appropriate staff supports would be put in place and recorded on the staff roster, these actions were not yet complete.

In addition inspectors found that although the staffing needs assessment was underway, the managers did not demonstrate that they were aware how this assessment was being completed or what criteria was being assessed by the person in charge to identify individual needs or risks. For example, to date the staffing needs at key times in the mornings and evenings had not been identified as a need - despite being identified as an urgent action, and no interim supports had been put in place. However, the PPIM gave assurances to the inspectors that they would implement additional supports in the interim while the staffing needs assessment was ongoing.

Inspectors reviewed the staff rosters in the centre and found that they did not reflect some staff on duty on the day of inspection. Inspectors were informed that certain shifts were never recorded on the roster. Likewise the hours spent by the person in charge within the centre were not recorded in the centre.

Staff files were not reviewed on this occasion as, in July 2018, they were found to contain all aspects required by Schedule 2.

Staff training records were reviewed. These indicated that training-gaps existed in relation to safeguarding, epilepsy and patient moving. Staff working in this centre also had need for training in positive behavioural support.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
At the time of the previous inspection two actions arose under this outcome. These related to a review of Schedule 5 policies and a review of resident files.

Inspectors found that resident files had been reviewed, resulting in the information contained therein being complete and accessible. However, one resident -who was temporarily moved back to the congregated setting, had no records or personal possessions maintained in the centre and their bedroom was completely vacant and only contained boxes to archive old files. Inspectors could not review the transitional planning around this move or assess if this placement was suitable to meet their needs in line with regulatory requirements.

At the time of this inspection the review of Schedule 5 policies was not due to be completed. Work on this was active at the time of this inspection.

Insurance records were not reviewed on this occasion as they had been made available to inspectors on 18 July 2018 and were found to be compliant.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Services Ireland
Centre ID:	OSV-0005139
Date of Inspection:	31 August 2018
Date of response:	08 November 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 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Not all service level agreements detailed the level of care and support provided in the centre, or the full details of the services provided and fees to be charged.

1. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the

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

provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
The residents have been provided with additional information by way of Appendix to on their Service Agreements on the level of care and support provided in the centre, and the full details of the services provided as outlined in the Statement of Purpose [30 August 2018]

The fees to be charged under the Residential Support Services Maintenance and Accommodation Contributions. (RSMACCS) Regulations - 4 September 2018

The additional costs to be borne by the residents for expenses not covered under the RSMACC Charges [4 September 2018]

Revised Service Agreements will issue to residents including the above [31/10/2018]

Proposed Timescale: 31/10/2018

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that arrangements were in place to meet the assessed needs of the residents in regard to their health and social care supports, transitional planning supports and staff supports in the centre.

2. 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:
The outcome of the assessment processed has been tracked to the personal plans/transition plans and staff roster planning to ensure that all assessed needs are included in the Centre's plans. This will be reviewed for completeness by 25 October 2018.

Proposed Timescale: 25/10/2018

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:
Storage within the house was limited, with a mop and bucket being stored within the shower of one en suite.

3. 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:
1. Staff have been instructed to store cleaning materials in the utility area provided.

2. The Provider will put in place additional storage shed in the Centre.

Proposed Timescale: 31/10/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some aspects of the centre required general maintenance such as a broken lamp and paintwork on the attic access, and ramp access to the front door.

4. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
1. The en-suite in one of the residents bedrooms will be enlarged to meet the needs of the resident and this change will be reflected in the floor plan for the building [26 September 2018]
2. The Person in Charge will review with the Occupational Therapist the necessity of the handrails outside the house to support one resident to mobilise safety outside their apartment and on finalising the separate garden parameters for the resident in the apartment. [30/09/2018]
3. The environment restriction on the use of the back garden area will be addressed by subdivision of the garden area to ensure the residents in the main house and in the apartment will have quite enjoyment of their respective external environments. 19 October 2018
4. The revised drawings for the Centre will be issued to the Authority. [19 October 2018]
5. The log of maintenance works in the Centre will be reviewed and updated to ensure all works are logged in the Centre [31/10/2018]

Proposed Timescale: 31/10/2018

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:
The provider failed to ensure that the there were appropriate systems in place to identify personal and organisational risks in the centre and put measures in place to manage and review these risks. In addition, there was no system in place in the centre to review accident and incident reports, or update information regarding incidents in the centre. No audits had been completed as part of the ongoing risk management of the centre.

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

Please state the actions you have taken or are planning to take:
1. The Provider has put in place a Risk Management Committee to oversee the Risk Register [15 October 2018]
2. The PPIM will Chair this Committee that will provide regular reports on key risk issues to the Provider.
3. All risks on the current risk register will be reviewed to ensure they are appropriately managed. [17 October 2018]
4. The Person in Charge/PPIM and Provider will ensure that all actions from Inspections by the Authority and from provider and internal inspections/audits are included in the risk management review and included in the register as appropriate.

Proposed Timescale: 25/10/2018

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
Inspectors found that infectious control practices were not in line with good practice guidelines as a mop and bucket was stored in the residents en-suite shower.

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

Please state the actions you have taken or are planning to take:
1. Staff have been instructed to store cleaning materials in the utility area provided.

2. The Person in Charge has reviewed the cleaning system using mops and has

upgraded it to minimise infection control risks. Staff have been issued with clear guidelines on the use of this system

Proposed Timescale: 10/10/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider did not ensure that there was an adequate evacuation procedure in the centre and that staff and residents were aware of the procedure to be followed in the event of a fire.

7. 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:
1. Staff will undertake regular evacuation drills.
2. All staff will ensure they have undertaken fire safety drills – actual or simulated in the Centre.

Proposed Timescale: 10/10/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure fire equipment was in proper working order.

8. Action Required:
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
1. The fire alarm and emergency lighting service checks were updated in the Centre [9/10/2018]
2. The fire doors were upgraded to meet standard and mechanical door closures are now in place [19/10/2018]

Proposed Timescale: 19/10/2018

Theme: Effective Services

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

requirement in the following respect:
The provider failed to put in place an effective auditing system to ensure that the fire equipment, and fire safety procedures, staff training and fire drills were effective and in line with regulatory requirements.

9. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
1. The Provider will ensure that a checklist is put in place to be completed by the Person in Charge and the Facilities manager for all renovation work. This checklist, to be held in the Centre, will provide evidence that the Centre has all the necessary checks in place
2. The weekly Fire Inspection Checklist has been updated to include additional checks
3. The audits to be conduction on fire safety and Management reporting systems included in the Fire Register in the Centre will be reviewed and upgraded as necessary

Proposed Timescale: 25/10/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Three staff did not receive the site specific fire training in the centre.

10. 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:
1. Core Staff Training delivered on 27 July – Relief Staff and new staff trained [29/08/2018] and 10/10/2018
2. Of the three staff identified in the report two staff did receive local site-specific fire safety training in the centre. The third staff was unavailable for training.
3. All staff fire-training records are now on the training matrix and the Person in Charge will ensure that no staff will commence roster duty without this mandatory training.

Proposed Timescale: 10/10/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

in the following respect:
All staff working in the centre did not have up to-date training in positive behaviour support.

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

Please state the actions you have taken or are planning to take:
1. Staff will partake of Positive Behaviour Support awareness training.
2. The progress of the longitudinal training for one staff and the corresponding development of the Behavioural for one resident commenced on 17 October 2018 will be shared with the staff team for joint learning on PBS Strategies

Proposed Timescale: 31/10/2018
Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Environmental restrictions were not managed in line with organisational or national policy.

12. 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:
1. Environmental restrictions on the use of external space will be addressed by separation of garden areas between the two residential units in the centre.
2. The risk of environmental restrictions not being processed in line with policy will be put on the risk register for shared learning.

Proposed Timescale: 25/10/2018
Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Therapeutic interventions were not utilized to ensure appropriate assessments of a residents behaviour were in place, prior to environmental and visiting restrictions being put in place.

13. 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:
1. Details of the Psychology supports available to two residents who transitioned in the year are available in the Centre

2. The therapeutic interventions utilised will be a core component of procedures for transfers/transitions in future.

Proposed Timescale: 31/10/2018

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. Safeguarding policies and procedures were not implemented to ensure residents safety was maintained and that they continued to feel protected.
2. The provider failed to put safeguarding procedures in place to protect residents finances from being used inappropriately, as identified on the last inspection.

14. 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:
1. The Staff Team have reviewed all safety protocols and compliance with these protocols will be part of the staff induction pack and team meetings
2. The Person in Charge has issued revised Centre Specific guidance on Residents Money, Household funds and Petty Cash.
3. A full review of residents' finances since November 2013 has been undertaken to ensure that residents have not been asked to contribute towards expenses that are covered in the residential contributions/charges. Any expense paid by residents in error has been fully refunded.
4. The staff have been reminded to be familiar with and implement Local Procedures on the management of service users' monies.
5. The local procedures will be reviewed for completeness by 25 October 2018

Proposed Timescale: 25/10/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all allegations of abuse logged in the centre had been reported to the office of the chief inspectors.

15. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
1. The Person in Charge has reviewed all incidents in the Centre to ensure that all notifiable events have been reported to the Authority. Retrospective notifications have issued for outstanding 3-day notifications. [7 September 2018]

2. The notifications will be reviewed for completeness by 31 October 2018

Proposed Timescale: 31/10/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all minor injuries recorded in the centre has been included in the quarterly notification to the office of the chief inspector in quarter 1 of 2018.

16. Action Required:
Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

Please state the actions you have taken or are planning to take:
1. The Person in Charge has reviewed all incidents in the Centre to ensure that all quarterly notifiable events have been reported to the Authority. [14 September 2018]
2. The notifications will be reviewed for completeness by 31 October 2018

Proposed Timescale: 31/10/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

The is failing to comply with a regulatory requirement in the following respect:
Assessments by an allied health professionals were not completed in a timely manner.

17. 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:
1. A communication assessment was completed on 6 September 2018 for one resident and recommendations will be implemented by 31/10/2018.
2. The Person in Charge and Provider has arranged for an updated needs assessment for the resident currently on respite to be completed as part of his transition plan. [11 September 2018]
3. The Person in Charge will ensure that the referral tracking system is fully updated and closely monitored by:-
• Ensuring all recommended assessments from assessment/intervention reports are included in the person's plans and on the referral tracking sheets, - this will be reviewed for completeness by 25 October 2018
• All referrals are followed up on a timely basis and interim consultations sought with clinicians where necessary. All referrals outstanding more than 5 months are monitored for action via the Centres Risk Management system for resolution.
4. The Person in Charge has ensured the referral for Behaviour Support Assessment can commence on 17 and 18 October 2018 and the behaviour support plan can be developed in conjunction with the resident's support worker's longitudinal training on this assessment and planning process.

Proposed Timescale: 31/10/2018

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:
The provider did not ensure that there were effective systems in place to ensure the centre was safe, appropriate to residents needs, and was effectively monitored.

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

Please state the actions you have taken or are planning to take:
The Provider will ensure that Managers including the PPIM and Director of Services are assigned appropriate Oversight Roles and provide regular reports on compliance with all regulations to ensure effective monitoring of the safety and the appropriateness of the care provided in the Centre.

Proposed Timescale: 31/10/2018

Theme: Leadership, Governance and Management

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

The provider failed to assure themselves that the workforce was meeting the residents assessed needs and regulatory requirements.

19. 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:
1. The staffing in the Centre has been reviewed to ensure it is adequate to support the needs of individual residents and for social and recreational activity. All supports previously held on a flexible basis will be included in the staff roster.
2. The Provider has sanctioned additional Staffing sanctioned for the Centre and these are to be effective from 19 October 2018

Proposed Timescale: 19/10/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While there was a clear management structure in the centre, the provider failed to ensure that the management team were meeting the requirement of their specify roles and responsibilities for all areas of service provision, including addressing action plan responses.

20. 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 Provider will set out a clear guideline on the roles and responsibilities of frontline staff, key workers, Team Leader, Person in Charge in the running of the Centre.

Proposed Timescale: 31/10/2018

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider did not ensure that the available resources were appropriately utilised in this centre and that there was resourced available meet the assessed needs of all

residents.

21. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The Person in Charge and Provider has reviewed staff supports with assessed needs and have increased staff rostered in the Centre on an incremental basis from 15 August 2018 to 19 October 2018.

Proposed Timescale: 19/10/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The registered provider failed address the urgent action issued in the previous inspection in relation to social staffing supports and on this inspection, they failed to identify current ongoing risks in the centre that required additional staff supervision in line with residents needs.

22. 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 Person in Charge has ensured that from 19 September 2018 the Resident House Meetings have standing agenda item for Social Activity Planning and that staff are rostered to support these needs.

Proposed Timescale: 19/09/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roster did not match the staff on duty.
The time worked by the person in charge within the centre was not recorded within the centre.

23. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota,

showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that the staff roster includes all support staff working in the Centre.

The Person in Charge will keep a roster of her time and activities in the Centre.

Proposed Timescale: 25/10/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training-gaps existed in relation to safeguarding, epilepsy, patient moving and responding to actual and potential aggression.

24. 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:
1. The Person in Charge will ensure that all staff mandatory and site specific training is updated
2. All difficulties encountered by the Person in Charge will be identified at the Risk Management Forum and management plans agreed.

Proposed Timescale: 25/10/2018

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Several Schedule 5 policies were beyond their review dates, but in the process of review, as previously agreed.

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

Please state the actions you have taken or are planning to take:
The Provider will ensure that all policies requiring review are updated and signed off by Board of Directors on 12 October 2018. Policies will be disseminated to the Centre by

31/10/2018

Proposed Timescale: 31/10/2018

Theme: Use of Information

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the additional records specified under schedule 4 were maintained in the centre.

26. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

Please state the actions you have taken or are planning to take:
The provider will review all records in the centre to ensure that all records as specified in Schedule 4 of the regulations are maintained in the centre.

Proposed Timescale: 25/10/2018

Theme: Use of Information

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider failed to maintain records for all residents in the centre, including residents on respite in line with schedule 3 requirements.

27. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
The provider will review all records in the centre to ensure that all records as specified in Schedule 3 of the regulations are maintained in the centre.

Proposed Timescale: 25/10/2018