<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Tús Nua</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0005415</td>
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<td>Centre county:</td>
<td>Wicklow</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Sunbeam House Services Company Limited by Guarantee</td>
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<tr>
<td>Provider Nominee:</td>
<td>Kate Hopkins</td>
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<tr>
<td>Lead inspector:</td>
<td>Ann-Marie O'Neill</td>
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<tr>
<td>Support inspector(s):</td>
<td>Raymond Lynch (Day 1) Paul Pearson (Day 2)</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
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<td>Number of vacancies on the date of inspection:</td>
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**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 following receipt of solicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
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<th>From:</th>
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<tr>
<td>13 September 2017 10:50</td>
<td>13 September 2017 21:00</td>
</tr>
<tr>
<td>05 October 2017 09:50</td>
<td>05 October 2017 11:50</td>
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The table below sets out the outcomes that were inspected against on this inspection.

| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs                                      |
| 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 17: Workforce                                             |
| Outcome 18: Records and documentation                             |

Summary of findings from this inspection

Background to the inspection.

This report sets out the findings of an unannounced inspection of a designated centre in operated by Sunbeam House Services Company Limited by Guarantee located in Bray County Wicklow. This inspection was the third inspection of this centre having been inspected in June 2016 as part of a ‘new build’ registration inspection and April 2017 approximately three months after residents moved into the centre.

Under the regulations the person in charge of a designated centre shall give the Chief Inspector notice in writing within three working days of any allegation, suspected or confirmed, of abuse of any resident. In the months prior to this inspection the Chief Inspector had received a significant number of notifications that identified safeguarding concerns.

Some notifications were not submitted to the Chief Inspector within the required timeframe in some instances with a time lapse by a period of weeks or months. In addition, these safeguarding incidents did not evidence that they were investigated as required through the National Safeguarding policies and procedures for the
safeguarding of vulnerable adults.

In response to this concerning pattern of incidents the Health Information and Quality Authority (HIQA) wrote to the person in charge and provider to seek assurances that this significant safeguarding risk was being appropriately managed. However, the responses received did not provide adequate assurance that the provider would implement timely and robust measures to manage the ongoing safeguarding risks.

As a result this triggered unannounced inspection of the centre was carried out to verify what steps the provider and person in charge were taking to ensure the safety of all residents and mitigate peer-to-peer incidents.

How we gathered our evidence
As part of the inspection inspectors visited the designated centre, met with all four residents present, the person in charge and spoke with regular Sunbeam employed staff and agency workers. Inspectors reviewed documentation such as, care plans, support plans, recording logs, policies and procedures. Residents communicated in their own preferred manner with inspectors. The residents allowed inspectors to observe their daily life in the centre.

Description of the service.
This designated centre is operated by Sunbeam House Services Limited by Guarantee and is based in Greystones County Wicklow. The provider is required by the Regulations to produce a document called the statement of purpose. The statement of purpose set out that the designated centre aimed to provide residential, day care and respite service for four male and female adults over the age of 18 with intellectual disabilities.

The centre comprises a bungalow; each resident had their own bedroom, the office used by staff was the en-suite bedroom in the centre. Residents had access to public transport and transport provided by Sunbeam House Services.

Overall judgments of our findings:

Overall, inspectors found the provider had failed to provide adequate assurances and evidence of considered and robust actions to address the previous inspection report and manage the ongoing significant safeguarding issues in this centre. The provider did not have systems in place to ensure the centre was monitored and action was taken when residents experienced harm.

The provider's risk management systems were not adequate. Risk was not being managed in a timely, robust and responsive way by the provider. This was resulting in on-going peer-to-peer risks to residents which were not identified, documented or effectively managed through a responsive risk management system.

As a result of the poor inspection findings inspectors took the unusual step of issuing immediate actions to address specific risks which required the provider to take specific action at the time of inspection.
Non compliances related to:
- Inadequate risk management systems to manage the significant ongoing safeguarding risk to residents which arose from peer-to-peer interactions.
- Lack of effective fire evacuation procedures
- Failure to demonstrate fire safety equipment in working order.
- Poor staffing arrangements, including agency staff, to have appropriate skills and knowledge to meet the needs of residents in particular relating to the management of behaviours that challenge
- Lack of guidance for staff on residents' care needs and the support planning to manage them was either absent or inaccurate and could pose a risk to residents given the number of agency workers in the centre.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.
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 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:**
The previous two inspection reports for this centre had identified residents had not been issued with a contract of care.

From reviewing a sample of documentation the inspectors observed that there were still no written contracts of care in place detailing the fees to be incurred by each resident or the services they were to receive.

This concerned the inspectors as some residents were paying for private consultations with allied health care professionals yet they (or their representatives) had not signed a contract of care agreeing to such charges.

This failing has been found consistently in all three inspections of this centre.

**Judgment:**
Non Compliant - Moderate

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

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

Findings:
Residents’ social care needs were not effectively managed through personal planning systems in the centre and this impacted negatively on residents. There was evidence to indicate where a need for a resident was identified through an assessment by an allied health professional there was a delay in that need being met by the provider.

Inspectors were concerned that residents were not supported to pursue activities and interests that were meaningful to them. On review of a residents’ personal plan they were identified as enjoying activities such as outings to the pub and swimming. However, on reading the daily activity logs there was evidence that these activities were not happening on a regular basis for the resident. Inspectors observed the resident sitting on an armchair in the living room of the centre for the entire period inspectors spent in the centre.

Overall, residents’ personal plans lacked evidence that they were consistently reviewed to take into account their effectiveness and to ensure that recommendations arising from them were implemented. Personal plans lacked evidence of a comprehensive assessment of residents’ needs informed by allied health professional assessments and recommendations. Therefore, it was not clear if in fact residents’ social care needs were being met due to the absence of assessment and review.

Following review by their mental health clinician, a resident had been reintroduced on medication to manage depression. However, the resident’s personal plan did not reference the reintroduction of this medication. Equally, there was no evidence of an ongoing assessment of the impact of this newly introduced medication on reducing the resident’s behaviours that challenge and depressive symptoms to evaluate its effectiveness and inform the resident’s clinician during follow up reviews.

Residents were sometimes required to pay themselves for private healthcare reviews if a public appointment was not available for them. There was evidence to indicate where a need for a resident was identified through an assessment by an allied health professional there was a delay in that need being met by the provider.

For example, the person in charge informed inspectors that the provider would generally pay for a private appointment for a resident if a medical emergency required it but if it was not a serious medical issue the resident stayed on a public waiting list for the appointment or paid for it themselves. The decision making around these referrals did not appear to be informed through an allied health professional assessment of the resident’s need.

For example, a resident had been identified by their general practitioner (GP) as
requiring a review by a dietician and had made a referral on behalf of the resident. At the time of inspection the resident had still not been seen by a dietician. The person in charge informed inspectors that they had requested the provider to pay for a private dietetic appointment, however, this was denied as it was deemed not a medical emergency. The person in charge showed inspectors emails of their request and the response from a financial manager within Sunbeam. Due to weight related issues the resident could not participate in activities that were important to them.

Person centred planning also required improvement to ensure residents identified goals were up-to-date and actions to support residents achieving them were outlined and implemented.

A more formalised approach to goal setting was required to ensure that when a goal was identified an action plan was developed which set out the steps required to achieve the goal and to ensure that it evidenced inclusion of the resident in establishing those steps, who was responsible and by what timeline.

Personal plans in some instances contained information that was not factually accurate with some information that required immediate removal from the plan. A resident’s care plan indicated that they were on two specific types of medication, one of which is generally prescribed for the management of epilepsy. However, on further investigation it became apparent that the resident in question was not prescribed either of these medications. The plan had been recently reviewed and signed off by the person in charge but the review had not picked up on this error. Further reference to this issue and the regulator’s directive to the provider are described in outcome 7; health and safety and risk management.

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:
A comprehensive risk management system had not been implemented in response to ongoing peer-to-peer assault risk in this centre. The provider did not have adequate oversight of risks in the centre. Fire safety management systems were also not adequate. Inspectors issued three immediate actions to the provider in relation to these serious non compliances requiring the provider to address them urgently. Inspectors
visited the centre 5 October 2017 to verify if the provider had implemented actions to address these risks.

Safeguarding incidents, notified to the Chief Inspector prior to the inspection, had outlined concerning information whereby a resident with sight loss was experiencing significant and consistent peer-to-peer assaults. They included being grabbed by the head and or neck by some of their peers resulting in staff having to intervene. One piece of documentation in the centre recorded that the assault could happen up to five times a day.

By way of example, one incident detailed a resident had grabbed their peer by the neck. The resident had gone red and was observed to be struggling resulting in staff needing to intervene. The most recent incident notified to the Chief Inspector in August 2017 detailed a similar incident whereby a resident had grabbed the left side of their peer’s neck with their hand. HIQA had received over 20 notifications of such incidents. This demonstrated that the provider had failed to respond and take effective action to protect the resident.

On this inspection, inspectors found an overall absence of any risk identification, assessment, analysis and identification of control measures to mitigate peer-to-peer risks. For example, residents’ personal risk assessments did not identify peer-to-peer assault as a risk relating to them. Safety plans for the resident who had been subject to the majority of peer-to-peer assault incidents documented that they were not at risk from their peers. Residents’ personal risk assessments had not identified that they were at risk of assault.

Inspectors were concerned that this potentially serious personal safety risk had been ongoing since residents moved into the centre, in total nine months previous. Equally there was no evidence that the high number of incidents of peer-to-peer assault recorded had escalated to senior management through the designated centre’s risk register and risk management systems. For example, the risk register for the centre did not identify that peer-to-peer assault was a risk in the centre.

Agency staff spoken with during the course of the inspection did not demonstrate any knowledge of residents’ personal risk or safeguarding planning. They could not tell inspectors how they should intervene in the event of a peer-to-peer incident occurring and they did not demonstrate any knowledge of the national safeguarding of vulnerable adult policies or advice associated with this National guidance.

Inspectors issued an immediate action for the provider to address the poor risk management systems in the centre in order to protect residents and manage peer-to-peer risks. A satisfactory response was received from the provider and the actions outlined in this response were observed to be in place on day two of this inspection.

Inspectors were also concerned with regards to the management of fire safety systems in the centre including evacuation of residents.

Staff in the centre were unable to demonstrate that all fire safety equipment in the centre had serviced and was in working order. While a fire consultancy representative
had visited the centre in May 2017, it was unclear as to what work had been undertaken and what equipment had been serviced. For example, servicing records for the fire alarm and emergency lighting were not available.

In order to verify servicing dates on equipment an inspector asked a staff member to open the encasing which fire extinguishers were being stored. The staff member was unable to open the container telling the inspector they did not know how to do so. This staff member was the only member of staff in the centre at the time the request was made meaning they could not access fire safety equipment which could be used for the first line management of a fire should one occur.

In addition to the above, the person in charge could not demonstrate if all fire safety equipment had been serviced as no such documentation was maintained in the centre. This meant the person in charge could not assure inspectors or themselves, that fire safety equipment in the centre was serviced as required and in working order.

In response inspectors issued an immediate action to the provider that they assure themselves that all fire safety equipment had been serviced and was in correct working order for the purposes of robust fire safety management.

Fire evacuation systems also required improvement. On reviewing fire drill records in the centre the most recent fire drill had taken 15 minutes to evacuate all four residents. However, 15 minutes was a significant period of time to evacuate only four ambulant persons from the centre and evidenced a lack of suitable arrangements in place in order to evacuate all residents from the centre in a timely way.

This was brought to the attention of the person in charge during the inspection, who could not explain this delay at the time of inspection. The person in charge contacted the staff member who conducted the fire drill. The staff member reported that one resident refused to co-operate with the drill resulting in the lengthy time. The fire drill record had documented there were no issues encountered on that fire drill. Furthermore, the personal evacuation plan for the resident who had not wished to co-operate with the drill had not been updated to address this issue or provide solutions and strategies for staff to implement to ensure the resident could be safely evacuated in future.

Overall, this was evidence of poor capture of risk relating to fire safety resulting in an absence of risk mitigation strategies and effective support planning for residents that would require such.

In response to this inspectors issued a third immediate action to the provider instructing them to immediately address this risk to ensure all residents could be evacuated safely from the centre.

The second day of inspection followed up on the provider’s actions to address the immediate risks identified by inspectors.

Individual personal risk assessments for residents had been documented. These set out the specific risks posed to residents and the measures in place to mitigate those risks.
The centre’s risk register had been updated to reflect the risk of peer-to-peer assault.

Inspectors found the provider had ensured all fire safety equipment was serviced on the 20 and 21 September 2017. This service had found fire extinguishers in the centre had been overdue for service. Records to evidence fire safety servicing were now maintained in the centre including a comprehensive fire register system in which staff would record their checks of equipment and exits.

A revised personal evacuation plan had been drawn up for the resident that required it and it now evidenced interventions which would support and incentivise the resident to evacuate from the centre in the event of an emergency. A practice drill had been initiated and a mobility aid had also been sought to further support the resident’s evacuation needs. The overall evacuation procedure for the centre had also been updated to reflect this specific evacuation requirement.

Due to the immediate risk mitigation as a result of immediate actions issued, inspectors were assured urgent risks had been mitigated. However, a major non compliance is still found in this outcome due to the provider’s absent risk management oversight and assurance mechanisms of the centre and reliance on the regulator to identify risk.

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:
There were poor systems in place to protect residents and ensure that they felt safe in their homes.

An immediate action was issued to the provider to assure HIQA that safeguarding risks were being mitigated. A further immediate action was issued in relation to the lack of information and assurances that all staff working in the centre, including agency staff, had the skills and knowledge to manage and implement strategies to manage
behaviours that challenge.

As outlined in outcome 7, there was an overall absence of risk management in the centre relating to peer-to-peer assault. Residents were at risk of experiencing peer-to-peer assault on a regular basis and this amounted to an unacceptable abusive situation. One resident who had experienced most of the directed assaults was particularly vulnerable due to their significant sight loss which meant they could not pre-empt an assault and protect themselves.

Staff spoken with during the course of the inspection did not demonstrate knowledge of safeguarding plans or measures they were required to implement in order to manage the ongoing risk of peer-to-peer abuse in this centre. Agency workers spoken with did not demonstrate any understanding of what strategies were in place to mitigate the risk or what steps they were to implement in response to an incident occurring. They also did not demonstrate knowledge of the provider's vulnerable adult safeguarding procedures that should be initiated when peer to peer incidents occur.

Inspectors issued an immediate action instructing the provider to protect all residents from incidents of peer to peer assault and to follow the provider's own safeguarding policy.

Inspectors requested to review the training information related to all staff, including agency staff that worked in the centre. However, training information relating agency workers was not maintained in the centre. The person in charge could not assure inspectors that those staff had the necessary skills and knowledge of safeguarding vulnerable adults policies and procedures, equally it was not clear if those workers had training and skills to manage behaviours that challenge.

During the inspection behaviour support planning strategies were drafted. The strategies prescribed would incorporate a low level of restraint in order to guide or physically move or guide residents if necessary in the event of an attempted or actual peer-to-peer assault occurring. However, inspectors were concerned as it was not evident that all staff had received appropriate training to implement this strategy in order to implement it correctly. This strategies also lacked multi-disciplinary input.

Inspectors issued a second immediate action to the provider to ensure all staff working in the centre had the necessary skills and training to manage behaviours that challenge and implement any strategy prescribed to mitigate and manage this risk.

Inspectors visited the centre again on the 5 October 2017 to seek assurances that the provider and person in charge had implemented the immediate actions issued by inspectors on the first day of inspection.

On the second day of inspection Sunbeam staff and the person in charge demonstrated a clearer understanding of safeguarding planning in place to support residents and prevent and manage peer-to-peer assaults. Strategies they described included, residents engaging in activities separately with some residents assigned a personal assistant to ensure those activities occurred. Staff also reported a resident was responding well to medication and this was also contributing to the reduction in peer-to-peer incidents.
While this was encouraging, agency workers spoken with still did not demonstrate adequate understanding of safeguarding planning and strategies for residents.

Since the first day of inspection three Sunbeam employed staff, including the person in charge, had received training in the management of behaviours that challenge implementation of the restraint strategies prescribed on the first day of inspection. A further two Sunbeam staff were due to attend this training the following week.

Inspectors reviewed the electronic incident recording system and daily notes for residents to verify if the frequency of peer-to-peer incidents had decreased. Evidence recorded indicated they had reduced.

The provider had also contacted all three agency providers they resourced agency workers from to retrieve training records for them. No agency worker that worked or had worked in the centre had training in safeguarding vulnerable adults or the management of behaviours that challenge.

Inspectors reviewed documentation relating to staff and found that the provider had not ensured that all staff in the centre had appropriate Garda vetting clearance. Inspectors wrote the provider directly after the inspection requiring take immediate action to address this. The provider responded by providing an assurance to HIQA that no staff member would be working in the centre until evidence of vetting was provided.

**Judgment:**
Non Compliant - Major

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

**Findings:**
The system in place to ensure notifications were submitted to the Chief inspector within the correct timeframe were ineffective. The provider was required to review and address the system failure.

Safeugardind notifications, as required by the regulations to be submitted within three days of the incident occurring, were not notified within that timeframe and in a number of instances were notified a number of weeks and in some instances, months late.
A safeguarding allegation referred to in the previous April 2017 inspection report of this centre and referenced as being under ‘trust in care’ investigation had not been notified to the Chief Inspector.

Subsequent to the inspection, and at the request of an inspector, the person in charge submitted the notification in full.

**Judgment:**  
Non Compliant - Moderate

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**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:**  
Inspectors were not assured residents were adequately supported to achieve their best possible health at all times. Significant improvements were required in relation to healthcare supporting planning to safely and accurately guide staff practices in the support of residents’ healthcare needs.

Where a resident required blood tests as part of a recommendation by their General Practitioner this had not occurred on at least two occasions due to the resident refusing the tests. Efforts had been made on one occasion, through the use of medication, to support the resident to undergo the tests. However, when this was unsuccessful, no other attempts to support the resident in undergoing this necessary medical test were made. Inspectors found that this was not an appropriate evidenced-based approach to support this resident to understand and cooperate with an important medical test.

The system in place for managing residents' healthcare needs included an assessment of their healthcare needs through a 'my health development plan'. Needs identified, using this assessment guide, should lead to the development of specific healthcare support plans to guide staff on how to provide care. However, the assessments were not informed by allied health care input and advice where it was needed. An action related to this is assigned in outcome 5 relating to comprehensive assessment of needs.

Residents’ healthcare planning, in some instances, was not adequate to guide staff practices in supporting healthcare needs. For example, a resident received daily checks of their urine for signs of infection. This resident was identified as requiring close observation with regards to this healthcare issue. The resident’s healthcare plan did not
document the necessity for such urine checks to take place. Equally, the plan did not set out what criteria staff were to assess during the checks or when the resident would require a review by their medical practitioner. It was not demonstrated that appropriate monitoring of this healthcare need was taking place.

Another support plan detailed a significant medical emergency that could occur for a resident related to their eyes. However, the support plan outlined no information as to how staff mitigated this medical emergency from occurring, for example management of self harm behaviour the resident engaged in which could aggravate the condition. The plan did not set out appropriate signs and symptoms which would alert staff to bring the resident to a medical practitioner. This was evidence of significantly poor healthcare planning for such a serious condition and required specific and timely review by the person in charge in conjunction with an appropriate allied health professional.

**Judgment:**  
Non Compliant - Moderate

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**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 provider failed to ensure the service provided was safe, appropriate to residents' needs and consistently and effectively monitored. Provider led systems that were in place to assess for safety and quality were not resulting in any effective changes in the centre and residents, as a result were experiencing a poor quality service and experiencing ongoing incidents of peer-to-peer assault as a result.

The provider was also failing to provide oversight and support to ensure the responsibilities of the person in charge were being managed effectively in this centre. For example, the implementation of actions as identified in provider led audits carried out in the centre and previous HIQA inspection action plans had not been implemented.

Inspectors reviewed the most recent provider led audit, a requirement of Regulation 23, which was carried out in June 2017. This audit, had identified a wide range of non
compliances which were similar to those identified on the April 2017 HIQA inspection. However, the provider had failed to ensure the actions were addressed. As a result residents continued to experience the poor outcomes identified in this report.

Inspectors requested an update from the person in charge with regards to what actions had been completed as a result of the June 2017 provider led audit. Only two actions had been completed Inspectors spoke with the person in charge who identified they found the operational management of two designated centres challenging and had raised this issue with the provider.

The provider had also failed to ensure timely and accurate incident recording in the centre by not ensuring all staff working in the centre had a way in which to document incidents when they occurred and contact a senior manager when they occurred in the absence of the person in charge. An inspector spoke with an agency staff member on duty who informed them that they did not have access to the electronic incident recording system in the centre. On the second day of inspection agency workers could still not document incidents on the system.

Despite the numerous and sometimes daily incidents relating to peer-to-peer assault that had occurred in the centre it was not evident that this escalated risk to residents had elicited a timely or comprehensive response from the provider or a review by them of the risk management systems in the centre. The provider had failed to respond in a timely and effective way to the ongoing risk of peer-to-peer assault in this centre. Their systems in place to detect risk and respond to its detection were inadequate.

The provider was required to implement effective internal assurance systems so that risk and welfare issues, such as the one that presented and escalated in this centre, were identified by the provider, in a timely way. When detected the provider was also required to implement robust and comprehensive systems to address them to ensure the care and welfare of all residents.

The provider also did not have effective systems in place to ensure all agency staff working in the centre had been appropriately vetted. This matter is addressed under Outcome 8.

**Judgment:**
Non Compliant - Major

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**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:
Staff numbers required review to ensure residents' needs were met. The skill mix was inadequate and there was an over reliance on agency staff to work in the centre. The provider was not proactively managing staff allocation and resources to ensure they were meeting the needs of residents by placing unskilled staff in the area of managing behaviours that challenge.

There was a number of regular agency and/or relief staff working in this centre. This was an ongoing issue that had been identified on the April 2017 inspection.

On occasion the provider used agency staff to cover various shifts where there was a staff shortage that could not be covered by regular Sunbeam staff or regular familiar agency staff. Agency staff in those instances were unfamiliar with the centre and residents. The staff rosters, however, showed no documented evidence of the names of the agency workers that had worked in the centre and what shift they had covered. This was concerning and evidenced a lack of systems in place to provide for investigation into any complaints, care practice, medication error, accident or incident, suspicion or allegation of abuse should they occur during those shifts, for example.

Inspectors reviewed if agency staff had appropriate training to meet the specific needs of residents, such as training in management of behaviours that challenge, administration of emergency rescue medication for the management of seizures and breakaway techniques. It was not demonstrated that this action had been addressed. The provider and person in charge did not have this information available to them.

Information available on the second day of inspection indicated no agency workers had training or had received training to meet the specific needs of residents living in this centre.

On the second day of inspection inspectors noted the number of agency workers in the centre had reduced. Improvements were evident. Some regular Sunbeam-employed workers had returned from annual leave, for example. The provider had also allocated another regular Sunbeam staff to the centre which had further increased the regular staffing resource for the centre. However, a sustainable staff resourcing plan was not in place. The provider was required to review the staffing resources for the centre and ensure there were enough resources to manage any absences of long term staff.

Judgment:
Non Compliant - Major

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

**Theme:**
Use of Information

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

**Findings:**
Inspectors were significantly concerned in the manner in which documentation pertaining to the care and welfare of residents was managed in this centre. The provider failed to assure the Chief Inspector that residents were protected against risks of unsafe or inappropriate care by maintaining incomplete and inaccurate documentation.

Not all documents as required under Schedule 3 of the regulations were available on the day of inspection. Records in all areas reviewed by inspectors relating to schedule 3 were either absent, incomplete or inaccurate and could not provide guidance to staff on appropriate care, safeguarding and risk management.

Not all documents as required under Schedule 4 of the regulations were available on the day of inspection. This included a record of each fire practice, drill or test of fire equipment (including fire alarm equipment) conducted in the designated centre and of any action taken to remedy any defects found in the fire equipment. A record of the number, type and maintenance record of fire-fighting equipment.

**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:

Ann-Marie O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Sunbeam House Services Company Limited by Guarantee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005415</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>13 September &amp; 05 October 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29 November 2017</td>
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</tbody>
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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 is failing to comply with a regulatory requirement in the following respect:
There were no written contracts of care signed by the residents and/or their representatives detailing the fees to be charged for services provided.

1. Action Required:

---

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
3 Service Level Provision Statements are now completed and in their file. A booklet is provided which includes details about the support, care and welfare of the resident. 1 Service Level Provision statement, remains with 1 client's family. Still in discussion with this resident's family re: signing and returning the form. Copy of RSSMAC, showing rent due, is kept in Personal Profile Folder.

Proposed Timescale: 18/12/2017

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence to indicate where a need for a resident was identified through an assessment by an allied health professional there was a delay in that need being met by the provider.

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 resident in question no longer requires a referral to a dietician for weight loss as he does not have an underlying medical issue. This has been discussed with the GP. GP letter in file to reflect this.
The resident is attending Weight Watchers and he has achieved his target weight and is back participating in activities that are important to him.
Care Plans have been amended to reflect this and staff are continuing to support this resident to make healthy choices to maintain his weight at its current level.

Proposed Timescale: 26/10/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans in some instances contained information that was not factually accurate with some information that required immediate removal from the plan.

3. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident’s assessed needs.

**Please state the actions you have taken or are planning to take:**
All Personal Plans were reviewed. Any information that was factually incorrect was removed.

**Proposed Timescale:** 26/10/2017  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A more formalised approach to goal setting was required to ensure when a goal was identified an action plan was developed which set out the steps required to achieve the goal, evidenced inclusion of the resident in establishing those steps, who was responsible to complete each step and by what timeline.

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

**Please state the actions you have taken or are planning to take:**
Quality Coordinator working one to one with staff to support them to complete P.O. assessment and will monitor the completion of this.  
5 Tus Nua staff recently attended Personal Planning training.  
3 resident have their P.O assessments completed and personal plans completed and in folder. 1 P.O assessment and personal plan still outstanding, quality coordinator calling to location on 30/11/17 review all personal plans and finalise the outstanding plan on 30/11/17.  
When these assessments are completed, and the Personal Plans devised, the PIC will ensure that recommendations arising out of each Personal Plan are recorded on CID using the 'P.P Priority Tab' and the names of those responsible for pursuing objectives in the plan will be recorded as well.  
The PIC and deputy PIC will review the Personal Plans monthly and monitor activities and how they are evidenced on CID on a weekly basis.

**Proposed Timescale:** 31/12/2017  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Where residents had been reviewed by their relevant allied health professional
information was recorded in their client information directory however, there was a lack of evidence that these reviews and any recommendations made from the reviews informed support planning or that support plans were updated following review.

5. Action Required:
Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

Please state the actions you have taken or are planning to take:
Care plans for all 4 residents now include recommendations from allied health professionals. SALT recommendations will be updated in care plans when report is received. The PIC will ensure that each Personal Plan is updated and read by staff as each action is identified. Staff will have to sign off that they have read updated care plans.

Proposed Timescale: 30/11/2017
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans lacked evidence of a comprehensive assessment of residents' needs informed by allied health professional assessments and recommendations. It was not demonstrated that social care needs were being met due to the absence of a comprehensive assessment of their needs.

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:
SALT assessments have been carried out on 4 residents on 16/11/17. Currently awaiting SALT report. 1 client is now being assessed by psychologist (Initial visit on 16/11/17) Physiotherapy is provided for residents as needed. Acting PIC rang O.T about making a referral on 28/11/17 and followed up with an email on 29/11/17.

This will be reflected in all 4 residents care plans

Proposed Timescale: 31/01/2018

Outcome 07: Health and Safety and Risk Management
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in
Inspectors found an overall absence of any risk identification, assessment, analysis and identification of control measures to mitigate peer-to-peer risks.

7. 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:
Review of Risk Assessments was carried out (29/11/17)
Peer to peer risk assessment completed that involved three residents (20/09/17).
Risk Assessment for peer to peer risks attached to Location Risk Register. Location Risk Register was updated on 22/11/17.
Control measures put in place to mitigate peer to peer risks and guidelines issued by PIC around safeguarding of 2 clients (20/09/17).

Care Plans, Safety Plans and Positive Support Plans have been amended and updated. An action plan has been put in place for the safeguarding and protection of all 4 clients and a safeguarding passport for each resident will be completed on 30/11/17.

Proposed Timescale: 06/12/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider could not demonstrate that all fire safety equipment in the centre was serviced and in 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:
Now using red “Fire Register Record” as well as SHS Fire Register Record. All individual examinations of fire safety equipment recorded in red “Fire Register Record”.
Hard copies of current certificate of examinations kept in SHS Fire Register Record.
List Serviced Records 21/09/2017

Proposed Timescale: 26/10/2017
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff on the day of inspection did not know how to access some fire extinguishers
9. **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:**
Location Induction Form amended to include how to access fire extinguishers for all new staff who work in our location. All staff now know how to access the fire extinguishers.

**Proposed Timescale:** 02/11/2017

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire evacuation systems could not ensure all residents could be safely evacuated.

Fire drills and information gathered from them, was not used to improve evacuation practices in the centre and for the purpose of updating or reviewing residents' personal evacuation planning.

10. **Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**
All PEEPs have been reviewed (29/11/17).
All residents can now be safely evacuated. Evacuation occurred on (29/11/17) and residents are able to evacuate safely with support.
Monthly house and car evacuations continued to be carried out and monthly inspections of fire safety equipment, first aid boxes and emergency lighting carried out. Daily inspections of means of escape carried out.

**Proposed Timescale:** 26/10/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence to indicate a restrictive strategy had been reviewed through a multidisciplinary team prior to being prescribed for the resident.

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

**Please state the actions you have taken or are planning to take:**
One resident has started being assessed by a psychologist who will review any restrictive practices. (Initial visit on 16/11/17).
All restrictive practices are presented for review to our Human Rights Committee and resubmitted annually.
All staff have been requested to read SHS Policy on Restrictive Practices. A copy of this has been left on location for staff and they will have to sign off when they have read it. The PIC will run a report to check that all staff have read it by 31 January 2018. All staff will receive training in the use of Restrictive Practices.
Care Plans have been amended to reflect this. MHID follow up due on the 30/11/17.

**Proposed Timescale:** 31/01/2018

**Theme:** Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not taken action to keep residents safe and to mitigate safeguarding risks in the centre in a timely and effective way.

The provider did not have systems in place to ensure all staff who worked in the centre had appropriate Garda vetting.

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

**Please state the actions you have taken or are planning to take:**
The Agency Staff member in question no longer works in SHS.
SHS HR Dept. do have systems in place to ensure that all staff are Garda vetted.

**Proposed Timescale:** 26/10/2017

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff working in the centre had the required knowledge or understanding of the National Safeguarding Vulnerable Adults policy and procedures.

13. **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:
One new staff member booked in to do the above training on Safeguarding and protection Training on the 17 November 2017. Hard copy of safeguarding policy is now available on location for staff. Safeguarding will be a topic for discussion on the agenda for each monthly staff meeting.

Proposed Timescale: 20/11/2017

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:
Notifications as required by the regulations were not notified within the timeframes as specified in the regulations and a number of instances were notified a number of weeks and in some instances months late.

14. 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:
This has been discussed at staff meetings and will be further discussed at staff meetings for the next six months. This will be on the Agenda for future staff meetings for the next six months.

Proposed Timescale: 26/10/2017

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:
Systems were not in place to ensure residents' healthcare needs were managed in a consistent way. Where a resident required blood to be taken as part of a recommendation by their General Practitioner, an evidence-based approach was not used to support the resident with this intervention. Where a resident required close monitoring of a medical need this had not occurred.

15. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.
Please state the actions you have taken or are planning to take:
One resident has a phobia about needles.
This has been discussed with his GP who have provided a letter about this which is held
in the client folder.
Staff will be in regular communication with the GP and continue to work pro-actively
with the client on this issue. A care plan has been created for skill development in
relation to GP visits.

Proposed Timescale: 17/11/2017

Outcome 14: Governance and Management
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
The provider had not put the appropriate systems in place to ensure the duties and
responsibilities of the person in charge were carried out. The person in charge had not
addressed a number of actions identified through provider led audits and HIQA
inspection action plans at the time of inspection.

16. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge
of the designated centre is full time and that the person in charge has the
qualifications, skills and experience necessary to manage the designated centre, having
regard to the size of the designated centre, the statement of purpose, and the number
and needs of the residents.

Please state the actions you have taken or are planning to take:
The duties of the PIC are under review by the provider. The below support systems are
currently in place.
• Monthly catch up meetings
• 3 monthly supervision meetings
• Annual appraisal
• Monthly CSM meetings (full group)
• 4 monthly CSM meeting with the SSM cluster
• Addressing of individual issues as they arise through phone call, emails, face to face
• Buddy system put in place for PIC with another PIC for support
• Staff Counselling Psychologist
• Regular meetings with previous HR Senior manager and SSM to address concerns
raised by PIC
• Another CSM assigned to cover for emergencies when PIC is on leave.
• Deputy PIC appointed

Proposed Timescale: 31/08/2018
Theme: Leadership, Governance and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put effective systems in place to monitor the service.

The provider failed to put effective systems in place to take corrective action when residents experienced harm.

The provider failed to ensure timely and accurate incident recording in the centre by not ensuring all staff working in the centre had a way in which to document incidents when they occurred.

17. **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:**
All agency staff members are issued with a password to enable them to log on to our Client Information Database. They have access to location residents’ CID profiles and are able to record information in an appropriate manner.
If for some reason they cannot log onto the system, they can record the necessary information as handwritten records in Client Care Record sheets, which are stored in Client Profile folders.

**Proposed Timescale:** 26/10/2017

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not put a plan in place to non compliances raised through their own audit.

18. **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:**
Acting PIC and deputy are carrying out the following audits on an ongoing basis
- Petty cash audit
- Client monies audit
- Housekeeping audit
- Medication audit
- 6 monthly internal audits are completed and all action plans will be implemented by
Acting PIC and deputy PIC will have a daily presence in the location. Supervision, staff meetings, annual appraisals and ensuring staff training is up to date. Families will be contacted by CSM and/or deputy CSM on a monthly basis to discuss the service and receive feedback.

Proposed Timescale: 22/12/2017

Outcome 17: Workforce
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was not proactively managing staff allocation and resources to ensure they were meeting the needs of residents by placing unskilled staff in the centre.

Staff skill mix was inadequate and an over reliance on agency staff to work in the centre was still the case.

The provider was required to review the staffing resources for the centre and ensure there were enough resources to manage any absences of long term staff.

19. 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:
PIC is liaising with HR Dept. to ensure the number, qualifications and skill mix of staff is appropriate.
Staffing levels have been increased to cover Personal Assistant for one of our residents.
All staff have relevant qualification to work in our location.
While we still have to employ agency staff, we use them in a minimal capacity and only when necessary.
They work in liaison with our regular staff.

Proposed Timescale: 02/01/2018
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff rosters showed no documented evidence of the names of the agency workers that had worked in the centre and what shift they had covered.
20. **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 roster has been reviewed and is now showing a planned and actual staff rota showing staff on duty at any time during the day and night. A monthly roster is now in place clearly outlining staff shifts.

**Proposed Timescale:** 26/10/2017

### Outcome 18: Records and documentation

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider did not have adequate schedule 2 records with regards to agency staff working in the centre.

21. **Action Required:**
Under Regulation 21 (2) you are required to: Retain records set out 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 for a period of not less than 7 years after the staff member has ceased to be employed in the designated centre.

Please state the actions you have taken or are planning to take:
Documents sent to PIC by HR Dept. Documents forwarded to Inspector by PIC

**Proposed Timescale:** 26/10/2017

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all documents as required under Schedule 3 of the regulations were available on the day of inspection. Records in all areas reviewed by inspectors relating to schedule 3 were either absent, incomplete or inaccurate and could not provide guidance to staff on appropriate care, safeguarding and risk management.

22. **Action Required:**
Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.
Please state the actions you have taken or are planning to take:
PIC has reviewed these documents and all absent, incomplete or inaccurate records have been removed or amended, to provide guidance to staff on appropriate care, safeguarding and risk management.

Proposed Timescale: 26/10/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all documents as required under Schedule 4 of the regulations were available on the day of inspection.

23. **Action Required:**
Under Regulation 21 (4) you are required to: Retain records set out in paragraphs (6), (11), (12), (13), and (14) of Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 4 years from the date of their making.

Please state the actions you have taken or are planning to take:
All records are now retained at the location.

Proposed Timescale: 26/10/2017