

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002480
Centre county:	Westmeath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Joseph Ruane
Lead inspector:	Lorraine Egan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 02 March 2016 10:10 To: 02 March 2016 20:15

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first inspection of this centre which comprised of one house and provided a residential service for six adults. Residents living in this centre had been assessed as having a mild to moderate intellectual disability and required support and supervision with activities of daily living. In addition to an intellectual disability, some residents had health, communication and behaviour support needs.

The centre was a semi-detached two storey house located in a town. It was within walking distance of the town centre and had been purchased by the service provider in the 1990's.

On the day of the inspection the inspector was told the person in charge was in the process of changing. The inspector met with both the outgoing person in charge and the incoming person in charge. The inspector also met with residents, staff and a person participating in management.

The inspector reviewed a variety of documents including residents' personal plans, medication documentation, risk management procedures, emergency plans and policies and procedures.

The governance systems in the centre were inadequate, ineffective and did not ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

On the day of inspection the incoming person in charge was required to respond immediately to a significant risk to residents. Some staff working in the centre had not received training in administering a medication which was prescribed to be administered to some residents in the event of a specific medical emergency. The findings and the immediate response by the incoming person in charge are outlined in Outcome 12.

All non-compliances identified on the inspection could be attributed to inadequate governance systems in the centre. The inspector's significant concern in regard to this was brought to the attention of those who attended the meeting at the end of the inspection. This included the incoming person in charge, the outgoing person in charge and those persons' line manager (who held the role of a person participating in management of the centre).

The inspector was informed that a clinical nurse manager 2 was in the process of returning to work and was being appointed as a frontline manager of the centre for 25 hours per week.

The inspector was not assured that a manager working 25 hours per week would have the time to adequately govern the centre and ensure the centre is in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (hereafter called the regulations).

The inspector inspected nine outcomes and none were found to be in compliance with the requirements of the regulations. Five outcomes were judged as moderate non-compliant and four outcomes were judged as major non-compliant.

Areas judged as moderate non-compliant were:

- Social Care Needs
- Safe and suitable premises
- Safeguarding and safety
- Workforce
- Records and documentation

Areas judged as major non-compliant were:

- Complaints (under Residents' Rights, Dignity and Consultation)
- Health and Safety and Risk Management
- Medication Management
- Governance and Management

The findings are outlined in the body of the report and the areas which required improvement are included 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):

This was the centre's first inspection by the Authority.

Findings:

The inspector did not inspect all aspects of this outcome.

The inspector noted respectful and friendly interaction between residents and staff. It was evident that residents and staff knew each other well, were comfortable in each others' company and positive relationships had developed and had been nurtured.

Residents spoken with said they liked the staff, trusted them and could speak with them if they had any concerns.

Staff spoken with were respectfully in their comments about residents and spoke passionately in relation to their desire to support residents to live full lives and achieve goals. However, staff said that they did not have management support to ensure they could always respond to residents' wishes. This is discussed further in outcome 14.

Management of Complaints:

The inspector reviewed the arrangements for responding to complaints. The document outlining how complaints were responded to was not specific to the centre and did not outline the persons responsible for responding to or overseeing complaints. In addition, the procedure was not displayed in the centre.

There was no evidence that residents and other potential complainants had been assisted to understand the procedure and their right to make a complaint.

The complaints log was reviewed by the inspector. A complaint had been made by a resident in June 2015 relating to a specific concern regarding the alleged treatment of them by a peer. It stated this was having a detrimental impact on the resident.

A response to this complaint was not documented. The staff on duty did not know if it had been responded to and when it was brought to the attention of management no explanation or clarification was provided.

The inspector reviewed the centre's procedures for the management of complaints. There was no documented person identified as responsible for responding to complaints in the centre. The person in charge's line manager told the inspector that this role was held by the clinical nurse manager 2 (CNM2). However, there was no CNM2 working in the centre.

In response, the person in charge's manager said that this role was undertaken by the most senior staff member in the absence of the CNM2. However, the inspector was told that this staff member was not aware that they had been assigned this responsibility and said they did not have time to carry out managerial roles alongside their frontline role supporting residents.

The procedure did not identify the persons to whom the complainant could appeal the outcome of a complaint and was not adequately clear in regard to the role of the person for ensuring that all complaints are responded to and records maintained.

At a meeting held at the end of the inspection, the management of complaints and the requirements of the provider under Regulation 34 was outlined by the inspector. From the responses received, the inspector was not assured that the person in charge or their line manager had adequate understanding of the requirements of Regulation 34 in regard to the management of complaints in a designated centre.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

The inspector did not inspect all aspects of this outcome.

A sample of residents' personal plans were viewed. A record of goals identified was maintained and there was evidence that some goals were being supported.

However, residents were not being supported to achieve all identified goals. For example, residents had identified a one night holiday as a goal. Staff had supported residents to identify a hotel and the staffing, transport and other required arrangements had been put in place.

The inspector was told that the evening before the residents were due to go on the break a staff member received a phone call from the outgoing person in charge stating that the holiday could not go ahead as it was not 'cost neutral'.

This was discussed with the outgoing person in charge who said that residents living in other centres had been supported to go on overnight breaks as they had ensured the break was 'cost neutral'. However, the inspector found the options outlined for ensuring that breaks were 'cost neutral' had not been suggested to or discussed with staff working in this centre and therefore residents were not supported in regard to this goal.

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector did not inspect all aspects of this outcome.

The centre comprised of a two storey semi-detached house located within walking distance of a town centre. The ground floor consisted of a kitchen, utility room, two sitting rooms and a downstairs bathroom with accessible shower. The first floor consisted of five bedrooms and a bathroom.

One large bedroom was used as a staff sleepover room, two residents had individual bedrooms and four residents shared a bedroom with one other person. Although the inspector was told that residents were happy sharing bedrooms, and a resident spoken with shared this view, there was no evidence of meaningful consultation or choice with residents in regard to sharing bedrooms.

In addition, a staff member told the inspector that a resident had verbally expressed wanting a bedroom of their own.

It was not satisfactorily evident why the largest bedroom in the centre was used as the staff sleepover room. The explanation provided by the outgoing person in charge was not adequate as only one resident had been given the option of moving to this bedroom.

One shared bedroom did not provide adequate screening around a bed. The screening did not close fully.

The house was 'homely' in decor and staff spoken with outlined how residents enjoyed having access to the two sitting rooms. On the evening of the inspection residents used both sitting rooms.

It was not evident the house was designed and laid out to meet the needs of the residents. The inspector noted the following areas had not been identified and/or addressed by the provider:

- the handrail on the stairs was on one side only
- the shower in the upstairs bathroom, which was used by all residents, was narrow
- the accessibility and future needs of residents in regard to the stairs and accessibility of the upstairs shower had not been assessed
- the sharing of bedrooms had not been assessed

In addition, the inspector noted the house had not been maintained to an adequate standard and there was no specific plan for addressing areas identified as requiring improvement. This included significant mould on ceilings and walls in residents' bedrooms.

The ineffective window and provision of heat in a resident's bedroom had been identified but had not been addressed. The bedroom was extremely cold on the evening of the inspection and the net curtain was moving in the wind when the window was closed. In addition, the radiator was not working. The room was small in size and the resident's bed was under the window. This was brought to the immediate attention of the persons in charge and their line manager.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

The inspector did not inspect all aspects of this outcome.

Fire Prevention and Safety:

It was not evident that all required fire safety management systems had been put in place. A fire risk assessment had been carried out in the centre by an external company in February 2015. The outgoing person in charge told the inspector that areas identified as requiring improvement had not been addressed as there was no funding allocated to address these areas.

The areas identified as requiring improvement included:

- structural changes, including additional insulation in the attic and self closers for doors
- upgrade to the fire alarm system
- additional emergency lighting

The inspector was told the fire alarm and fire equipment was serviced annually and viewed documentation in relation to this.

There was no overarching centre specific evacuation plan in place to outline the overall plan for evacuating the centre.

Individualised evacuation plans were in place for residents. However, the information outlined required review as residents' specific support needs were not detailed. For example, a plan stated a resident 'needs assistance' to evacuate but did not specify the assistance required.

In addition, the inspector was not assured these plans were reviewed to ensure they contained the most up-to-date information. There was no date of completion and some information was inconsistent with the findings on the inspection in relation to measures which had been implemented to support a resident.

Fire drill records were maintained. Three fire drills had taken place since November 2014. There was no record of fire drills prior to this. None of these fire drills took place at night. It was not evident that fire drills were taking place at suitable intervals to ensure that all staff and residents were aware of the procedure to be followed in the event of a fire.

Risk Management:

Risk assessments had been carried out and actions identified and responded to. However, the inspector found a risk in relation to the container for holding needles and other sharp items which had not been risk assessed and control measures implemented. There was no lock on the 'sharps' container and it was stored in a cupboard which could be easily accessed by residents.

The inspector reviewed the record of accidents and incidents. Some incidents were not documented as responded to. On reviewing these incidents the inspector was concerned that some incidents which related to residents were not being responded to.

For example, one related to the inappropriate way a resident spoke of another resident and another related to a concern regarding possible peer to peer bullying and financial abuse. These had not been documented as responded to by the provider or person in charge.

The inspector raised this at the meeting held at the end of the inspection and neither the incoming or outgoing persons in charge were aware of these incidents. This raised concern that the systems in place for the assessment, management and ongoing review of risk in the centre were not effective.

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector did not inspect all aspects of this outcome.

There was evidence that the use of restrictive practices in the centre had been reviewed and alternative measures implemented.

The centre had implemented some measures to protect residents being harmed or suffering abuse. However, documented complaints and incident report forms raised concern that allegations of abuse may not be identified or responded to in the centre. The inspector was therefore not assured that all required measures had been implemented to ensure residents were protected from all forms of abuse.

Some residents required support with behaviours that challenge. Some work had commenced in regard to compiling a behaviour support plan for a resident. However, it was not evident that all relevant information had been compiled to ensure the support plan was robust and appropriate interventions were implemented. Staff working with the resident had not been involved in identifying the interventions.

A resident requiring support with aspects of behaviour that was challenging for staff had not received any support in relation to this. The lack of response by the provider in regard to supporting this resident had the potential to impact negatively on their life. This had not been identified by the person in charge or provider.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

The inspector did not inspect all aspects of this outcome.

There were written policies relating to the ordering, prescribing, storing and administration of medicines to residents. Improvement was required to residents' prescription sheets, the assessment of self administration of medicines by residents and the training for staff to ensure that PRN (as required) medicines could be administered to residents when necessary.

Medicines were administered by registered nurses. The inspector was told that a nurse working in another centre administered medicines when the centre nurse was not on duty.

The staff nurse outlined the process in place for the handling of medicines, these were safe and in line with current guidelines and legislation.

There were appropriate procedures for handling and disposing of unused and out-of-date medicines.

The inspector viewed a sample of prescription sheets and found they contained all required information with the exception of the specific prescribed time for some medicines to be administered.

Two residents were administering their own medication. The staff nurse said that these residents had taken responsibility for their medication since they came to live in the centre. However, a risk assessment and assessment of capacity had not been carried out with these residents.

A staff member had not received training in administering a medication which was prescribed to be administered if a resident had a specific medical emergency. This raised significant concern as the staff member was providing one to one support for a resident on a daily basis since September 2015 and had worked alone in the centre with two residents who were prescribed this medication.

This had not been identified by the incoming or outgoing person in charge or the provider nominee. The inspector identified this significant risk and required the incoming person in charge to respond to this immediately. The incoming person in charge informed the inspector that a staff member trained in administering this medication would be assigned to working with residents until such time as the staff member had received this training.

Judgment:

Non Compliant - Major

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

As outlined in outcomes 1, 5, 6, 7, 8, 12 and 17 significant improvements were required to ensure that systems were in place to ensure residents' needs were met and the service provided was safe, appropriate to residents' needs, consistent and effectively

monitored.

The findings on the day of the inspection raised significant concern that the inadequate oversight of the centre was having, and had the potential to have, negative impacts for residents. It was therefore not evident that the person in charge had the 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.

In the weeks prior to the inspection, a new person in charge had been appointed. She told the inspector she had been absent from her role for a period of weeks and therefore had not had adequate time to become accustomed to the role.

The inspector asked the incoming person in charge to provide assurance regarding the training provided to staff in administering a medication which was prescribed for residents in a specific medical emergency to the inspector in writing the day after the inspection. However, this information was not received in a timely manner as requested. The inspector contacted the person in charge and the provider nominee regarding this and received this assurance in writing one week after the inspection.

The inspector met with the outgoing person in charge. He told the inspector that he had been person in charge of ten community-based residential houses and it was not possible to provide effective governance and oversight of ten houses. He said he was now person in charge of three centres.

Having spoken with both the incoming and outgoing person in charge the inspector remained unclear in regard to the governance of the centre. Although the management structure was clearly defined, the roles and responsibilities were not clear, and a key management post was vacant.

The vacant management post was a clinical nurse manager 2 (CNM2) post. The inspector was told the previous CNM2 had been moved to another centre a year prior to the inspection and had not been replaced. A system to ensure the centre was governed effectively while CNM2 post was vacant had not been implemented.

The inspector was told that a CNM2 had been identified to work in the centre for 25 hours per week. The CNM2 was due to commence in the coming weeks. The inspector was concerned that, given the findings on the day of the inspection, the allocated hours would be insufficient to govern the centre on a day to day basis, address the non-compliances identified on this inspection and proactively ensure the centre is in compliance with the regulations. The inspector's concern in regard to this was outlined to the persons who attended the meeting at the end of the inspection.

There was some discussion regarding the future purpose of the centre. The inspector was told it had been identified that some residents living in the centre did not require the level of support currently provided. It was therefore proposed that the centre may be more suited to an independent living support service with support hours based on the assessed needs of the residents.

However, the inspector was concerned that there was no formal assessment of residents' support needs and no evidence that residents were being supported to become more independent in life skills to enable them to live in the centre with decreased staffing support. For example, although it was identified that staffing may not be required at night there had been no fire drills at night and it was therefore not evident that this had been considered as part of the discussion.

There was no annual review of the quality and safety of care and support in the centre. The inspector was told some information had been compiled but that the review had not been completed.

Unannounced visits to the designated centre had not been carried out. The inspector was told that dates had been set for these to take place in 2016.

Findings on the inspection raised concern that the 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 were not effective. The post identified as having responsibility for this was vacant (CNM2).

Staff were not being adequately facilitated to raise concerns about the quality and safety of the care and support provided to residents. For example, in relation to the support for residents to achieve goals and access to transport to ensure residents' wishes could be facilitated.

Judgment:
Non Compliant - Major

Outcome 17: Workforce

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

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector did not inspect all aspects of this outcome.

Staff Training:

The training records provided did not provide assurance that all staff had received required training and that there was effective oversight of training in the centre.

Throughout the inspection the inspector was given three documents which showed the training provided to staff working in the centre. All three differed and therefore did not assure the inspector that the information provided was accurate.

In addition, some information on the training records were highlighted as inaccurate by the incoming person in charge and the senior person participating in management at the meeting held at the end of the inspection. It was therefore not evident that all staff had received required training. This included training in the prevention, detection and response to suspected or confirmed allegations of abuse and minimal handling for one staff member and training in the management of behaviour that is challenging including de-escalation and intervention techniques for all staff.

Some staff were employed by external organisations, for example staffing agencies. The inspector was told that the service provider had been informed that all staff employed by external agencies had received training in manual handling, the prevention, detection and response to suspected or confirmed allegations of abuse and CPR (cardiopulmonary resuscitation). However, there was no evidence of this maintained and no assurance that staff had received required training in fire prevention, emergency procedures and first aid fire fighting equipment, the prevention, detection and response to suspected or confirmed allegations of abuse and the management of behaviour that is challenging including de-escalation and intervention techniques.

Staff rota:

The inspector requested a copy of the staffing rota for the centre and was informed there was no rota in the centre. Staff said they worked a fixed rota and therefore knew what their working hours were.

Staff said a CNM2 working in a different centre compiled the staff rota for the house and was sometimes delayed in putting a copy of the rota in the centre.

The rota from the previous week was viewed. The rota did not contain the start and finish times of all working shifts and the day staff commencement time was not consistent with the information provided to the inspector.

The fixed nature of the rota raised concern that the staffing levels and skill mix were not adjusted in response to residents' needs. In addition, the inspector was concerned that every weekend a single staff member worked from Saturday morning to Monday morning. The potential negative impact of this on the service provided to residents had not been assessed.

Judgment:

Non Compliant - Moderate

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector did not inspect all aspects of this outcome.

Staff Files:

The inspector viewed a sample of staff files. At a meeting with the incoming and outgoing persons in charge the inspector was told that an external company had been hired to complete an audit of staff files and no issues had been identified.

However, the inspector found the staff files did not contain all items required by the regulations. For example, a staff nurse's 2016 registration with the Nursing and Midwifery Board of Ireland, a full employment history for each staff member and documentary evidence of relevant qualifications.

The centre did not have documentary evidence required by the regulations for staff working in the centre and employed by external organisations. This included evidence of Garda vetting, a copy of the staff member's identification and references.

Directory of Residents:

The directory of residents did not contain the date residents came to reside in the designated centre.

Policies:

The centre had a copy of policies as required in Schedule 5 of the regulations. However, the policies were not specific to the centre and there was no system in place to ensure staff read, understood and agreed to adhere to the policies and procedures. The complaints policy and aspects of the medication policy were not implemented in the centre.

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:

Lorraine Egan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002480
Date of Inspection:	02 March 2016
Date of response:	12 April 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The complaints procedure for residents was not effective, was not in an accessible and appropriate format and did not include an appeals procedure.

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

1. Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

A process map has been developed for the designated centre outlining the steps to take in the event of a complaint being made by a resident.

Four staff in the designated centre have completed training in complaints as at 14th March 2016. The remaining staff currently working in the designated centre are completing complaints training on 14th April 2016.

A local complaints policy is being developed for the designated centre. The policy will reflect the existing accessible complaints procedure and the HSE Your Service Your Say policy.

An appeals mechanism in flowchart format will accompany the policy and HSE Your Service Your Say policy.

Proposed Timescale: 18/05/2016

Theme: Individualised Supports and Care

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

A copy of the complaints procedure was not displayed in a prominent position in the designated centre.

2. Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

The accessible complaints document is currently being reviewed in line with the development of a local complaints policy. The new accessible complaints document and the Your Service Your Say document will be placed in the hallway of the designated centre to ensure that it is in a prominent position.

Proposed Timescale: 06/04/2016

Theme: Individualised Supports and Care

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

A complaint made by a resident was not investigated.

3. Action Required:

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

The person in charge has met with the individual resident in relation to the complaint. The assistant director of nursing will complete a desktop review with the person in charge to address the complaint made by the resident.

The documentation and outcomes of all complaints and investigations into complaints will now be filed in the individuals' care plan.

Proposed Timescale: 15/04/2016**Theme: Individualised Supports and Care****The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Complainants were not assisted to understand the complaints procedure.

4. Action Required:

Under Regulation 34 (2) (c) you are required to: Ensure that complainants are assisted to understand the complaints procedure.

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

A local complaints policy is being developed for the designated centre. The policy will reflect the existing accessible complaints procedure and the HSE Your Service Your Say policy.

An appeals mechanism in flowchart format will accompany the policy.

The complaints policy and accessible complaints procedure will be discussed at weekly house meeting on Monday 16th May with residents and the PIC.

Proposed Timescale: 18/05/2016**Theme: Individualised Supports and Care****The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was no nominated person with responsibility for ensuring a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied was maintained.

5. Action Required:

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

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

The PIC is identified as the nominated person who will maintain a record of all complaints including investigation details, actions taken and outcomes of the complaint made and whether the resident is satisfied with the outcome of the complaint.

Proposed Timescale: 18/05/2016

Theme: Individualised Supports and Care

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

A person had not been nominated to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

6. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

A local complaints policy is being developed for the designated centre. The policy will reflect the existing accessible complaints procedure and the HSE Your Service Your Say policy.

A complaints officer has been identified and this information will be made available to residents in the designated centre in line with the new complaints policy.

The complaints policy will be explained to the residents by the PIC at their weekly house meeting on Monday 16th May 2016 using the accessible complaints document. The complaints procedure (accessible document) will be displayed within the designated centre.

The ADON is identified as the nominated person who will ensure that all complaints are appropriately responded to and ensures that the PIC maintains a record of all complaints including investigation details, actions taken and outcomes of the complaint made and whether the resident is satisfied with the outcome of the complaint.

Proposed Timescale: 10/06/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

There were inadequate arrangements in place to meet the assessed needs of each resident.

7. Action Required:

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

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

All residents in the designated centre will be supported to have a person centred planning meeting to identify their individual goals. This will include the organisation of holidays as appropriate and a plan will be put in place by the key worker to support the resident in achieving their goals.

The Person centred planning guideline will be revised to include a barrier form. This form will inform of any barriers which prevent residents from achieving their goals. A flowchart will be developed to outline the process: the residents key-worker will complete the barrier form as appropriate and forward to the PIC. The PIC will risk assess this and where the issue cannot be addressed locally the PIC will escalate to senior management.

Resident's holidays will also be discussed with residents at house meetings.

Proposed Timescale: 30/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

It was not evident the premises were designed and laid out to meet the number and needs of residents.

8. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

Consultation with residents in the designated centre took place on 30th April 2016 to discuss their satisfaction with their current bedrooms and accommodation arrangements within the designated centre and to include the opportunity for residents to utilise the larger bedroom where so desired.

Outcome of the discussions to date with residents has been documented.

For each individual where specific bedroom accommodation needs and preferences are identified an action plan will be devised and implemented to address their bedroom accommodation needs/preferences and to assist with reaching individual goals.

In the interim a review of the privacy screens has been undertaken by the manager of the house and provision has been made to alter the privacy screen to ensure that the privacy and dignity of the residents is maintained.

A meeting took place with the Estates department on Friday 6th May 2016 to discuss the designated centre. It was agreed that further consultation with the residents, staff and members of the multidisciplinary team (Occupational Therapist and Physiotherapist) will take place by the 30th June 2016 to identify recommendations to be addressed in relation to residents' ability to access bathroom facilities and the stairwell. Consultation with residents and their families has commenced to address residents' accommodation requirements.

In collaboration with Estates Department alternative suitable accommodation for two residents will be identified in line with their assessed needs and preferences, reducing the number of residents down from six to four in the designated centre by 30th December 2016. Every effort will be made to expedite this process for both residents sooner than the action date identified 30th December 2016.

A review of the designated centre by senior management with Estates and Maintenance Departments took place on the 13th June 2016 to address the assessed needs of residents of the designated centre specifically in relation to accessing the stairs and upstairs bathroom. See below programme of work to address accessibility issues regarding the upstairs bathroom and stairs in the designated centre by either recessing handrail or widening stairs and completely refurbishing the upstairs bathroom. These proposed works are subject to the availability of funding which has not been identified as yet.

Project Stages	Timeframe
Preparation of Tender Works Package	2.5 Months (End August)
Tender Period/Appointment of Contractor	1.5 Months (Mid-October)
Construction Phase	2.5 Months (End December)

Proposed Timescale: 30/12/2016

Theme: Effective Services

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

The premises was not kept in a good state of repair externally and internally.

9. Action Required:

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

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

The maintenance manager has conducted a walk-about of the designated centre with a view to completing a programme of works.

The repair and painting of the ceiling and walls in two resident's bedrooms will be completed by 20th May 2016.

The window repair in one resident's bedroom will be completed by 30th April 2016. In the interim the resident's bed has been moved away from the window and the radiator has been repaired on the 23rd March 2016.

All ineffective radiators (single radiators) will be replaced with double radiators in the designated centre by 30th May 2016.

Proposed Timescale: 30/05/2016

Theme: Effective Services

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

The premises was not equipped with all necessary aids to support and promote the full capabilities and independence of residents.

10. Action Required:

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

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

A review will be undertaken by an occupational therapist in relation to adequacy of the supports currently in place for individuals to use the stairwell. The referrals will be completed by 13th April 2016.

An assessment will be undertaken by an occupational therapist and physiotherapist in relation to individuals' ability to access the bathroom facilities. The referrals will be completed by 13th April 2016.

Bathroom facilities in the designated centre will be assessed by the occupational therapist and physiotherapist. The referrals will be completed 13th April 2016.

A meeting took place with the Estates department on Friday 6th May 2016 to discuss the designated centre. It was agreed that further consultation with the residents, staff and members of the multidisciplinary team (Occupational Therapist and Physiotherapist) will take place by the 30th June 2016 to identify recommendations to be addressed in

relation to residents' ability to access bathroom facilities and the stairwell. Consultation with residents and their families has commenced to address residents' accommodation requirements.

In collaboration with Estates Department alternative suitable accommodation for two residents will be identified in line with their assessed needs and preferences, reducing the number of residents down from six to four in the designated centre by 30th December 2016. Every effort will be made to expedite this process for both residents sooner than the action date identified 30th December 2016.

A review of the designated centre by senior management with Estates and Maintenance Departments took place on the 13th June 2016 to address the assessed needs of residents of the designated centre specifically in relation to accessing the stairs and upstairs bathroom. See below programme of work to address accessibility issues regarding the upstairs bathroom and stairs in the designated centre by either recessing handrail or widening stairs and completely refurbishing the upstairs bathroom. These proposed works are subject to the availability of funding which has not been identified as yet.

Project Stages	Timeframe
Preparation of Tender Works Package	2.5 Months (End August)
Tender Period/Appointment of Contractor	1.5 Months (Mid-October)
Construction Phase	2.5 Months (End December)

Proposed Timescale: 30/12/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The systems in place for the assessment, management and ongoing review of risk were not effective.

11. 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:

Risks in relation to a container holding needles and other sharp items will be assessed by the house manager and control measures implemented.

There is now a lock on the sharps container and it is stored in a safe and locked location.

A desktop review of all accidents and incidents in the designated centre will be completed by the manager and the person in charge.

A preliminary screening for incidents will be completed by the house manager and the Person in Charge and all incidents will be responded to accordingly.

All notifiable accidents and incidents will be notified to HIQA by the Person in Charge.

A system is now in place to review specific incidents and complaints accidents via a traffic light system on a fortnightly basis within a Quality Assurance Group specific to the service. This designated centre is scheduled for review on 24th May 2016. Outcomes will be documented in the minutes of this meeting.

Proposed Timescale: 24/05/2016

Theme: Effective Services

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

Fire drills were not taking place at suitable intervals to ensure that all staff and, as far as was reasonably practicable, residents, were aware of the procedure to be followed in the case of fire.

There was no overarching evacuation plan and residents' individual evacuation plans were not adequately specific and did not contain the most up-to-date information.

12. 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:

Day time fire drills will take place, initially, every fortnight, following the residents' meeting to ensure that everyone is aware of the procedure to be followed in the event of a fire.

A deep sleep fire drill will take place in the designated centre by the 20th May 2016.

The Fire Prevention and Safety Officer will carry out a review of the fire safety concerns in the designated centre with the Person in Charge/Clinical Nurse Manager on the 11th May 2016.

The Person in Charge/Clinical Nurse Manager in consultation with the Fire Prevention and Safety Officer on the 11th May 2016 will complete an overarching evacuation plan for the designated centre. Residents' individual evacuation plans will also be revised to contain the most up-to-date information.

Proposed Timescale: 20/05/2016

Theme: Effective Services

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

Required fire safety management systems had not been put in place.

13. 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:

The external fire safety report completed in February 2015 is now available in the designated centre.

The depth of the insulation in the attic will be increased to a minimum 150mm for 30 minute rated ceilings. This will be completed by 31st August 2016.

Self-closers will be in place for all doors in the designated centre with the exception of bedroom doors as per HTM05-03K.

The fire alarm system in the designated centre will be upgraded.

Additional emergency lighting in the designated centre will be put in place.

The hot press will be fitted with FD30S fire rated doors

All existing service penetrations in the ceiling membrane will be fire stopped

All staff will have a master key for the bedroom doors on their person at all times

The front and back door of the designated centre will be fitted with tum turn devices

The lock on the gate at the side entrance to the designate centre has been removed

Emergency lighting will be provided to escape routes in according with IS3217 2013

Proposed Timescale: 31/08/2016

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:

Every effort to identify and alleviate the cause of residents' behaviour was not made.

14. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

A referral has been made to the behaviour support team to support the resident displaying behaviour of concern.

The behavioural support team met with the resident and staff team in conjunction with the resident's key worker and reviewed the personal plan of the resident who displayed behaviours of concern in the designated centre on the 19th April 2016. Further meetings took place with the resident and the behaviour support nurse on the 29th April 2016 and on the 4th May 2016.

Skills training has commenced in communication and relationships with a qualified instructor for the resident. To date the resident has availed of two sessions of skills training. On completion this programme will be reviewed with the resident and behaviour support team.

Proposed Timescale: 30/06/2016

Theme: Safe Services

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

It was not evident that residents were being adequately protected from the risk of abuse.

15. Action Required:

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

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

A desktop review of all accidents and incidents in the designated centre will be completed by the manager and the person in charge.

A preliminary screening for incidents in designated centre will be completed by the house manager in conjunction with the Person in Charge and all incidents will be responded to.

All notifiable accidents and incidents in the designated centre will be notified to HIQA by the Person in Charge.

A system is now in place to review specific incidents and complaints accidents via a traffic light system on a fortnightly basis within a Quality Assurance Group specific to the service. This designated centre is scheduled for review on 24th May 2016.

Outcomes will be documented in the minutes of this meeting.

Proposed Timescale: 24/05/2016

Outcome 12. Medication Management

Theme: Health and Development

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

A risk assessment and assessment of capacity had not been carried out with residents who had responsibility for the administration of their own medication.

16. Action Required:

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

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

Two healthcare assistants working in the designated centre will receive training in the Safe Administration of Medication.

The prescription sheets in the designated centre for each resident will be reviewed by the Person in Charge and the pharmacist.

A typed prescription sheet for each resident in the designated centre will be implemented in conjunction with the pharmacist.

Each resident who is self-administering medication will have a risk assessment and an assessment of capacity completed.

All residents will have a risk assessment and an assessment of capacity completed in relation to the administration of medication.

Proposed Timescale: 31/05/2016

Theme: Health and Development

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

The practices relating to the administration of medicines prescribed to be administered in a specific medical emergency were not appropriate and suitable to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed.

17. Action Required:

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

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

All staff working in the designated centre are trained in the administration of emergency medication for epilepsy.

Proposed Timescale: 11/03/2016

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:

It was not evident that the person in charge had the 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.

18. 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:

A full time Clinical Nurse Manager II is now in place in the designated centre to support the Person in Charge. Provision is made for 15 hours per week protected time to this manager for the advancement of quality improvement initiatives.

Supervision meetings will be conducted by the Regional Director of Nursing with the Person in Charge with a view to increasing the skills and identifying skills gaps required to manage the designated centre.

Supervision meetings will be conducted by the Person in Charge with the Clinical Nurse Manager with a view to increasing the skills and identifying skills gaps required to manage the designated centre.

Supervision meetings will be conducted by Clinical Nurse Manager with the staff of the designated centre with a view to increasing the skills and identifying skills gaps required to operate and manage the designated centre.

Proposed Timescale: 31/07/2016

Theme: Leadership, Governance and Management

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

The management structure in the designated centre did not clearly identify the lines of authority and accountability, specify roles, and detail responsibilities for all areas of service provision.

19. 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:

A review has been carried out of the management structure in the designated centre. The organigram will be represented in the revised statement of purpose and available to view separately as a stand-alone document in the designated centre.

There is a nominated PIC for the designated centre who is responsible for all areas of service provision within the designated centre. The PIC works 5/7 in the designated centre. In the absence of the PIC the support staff working in the designated centre on the day is the person in charge. This person is identifiable on the planned and actual roster for the designated centre. There is a new nominated PPIM in the service covering the designated centre. There is a 24 hour manager on duty/manager on call available to the PIC/Designated Centre at DON/ADON/CNM level.

Proposed Timescale: 13/06/2016

Theme: Leadership, Governance and Management

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

The management systems in the designated centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

20. Action Required:

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

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

A full time Clinical Nurse Manager II is now in place in the designated centre to support the Person in Charge. Provision is made for 15 hours per week protected time to this manager for the advancement of quality improvement initiatives.

Supervision meetings will be conducted by the Regional Director of Nursing with the Person in Charge with a view to increasing the skills and identifying skills gaps required to manage the designated centre.

Supervision meetings will be conducted by the Person in Charge with the Clinical Nurse Manager with a view to increasing the skills and identifying skills gaps required to manage the designated centre.

Supervision meetings will be conducted by Clinical Nurse Manager with the staff of the designated centre with a view to increasing the skills and identifying skills gaps required to operate and manage the designated centre.

A schedule has been drafted for the Person in Charge to meet with the manager in the designated centre weekly commencing 13th April 2016 to provide further monitoring.

Proposed Timescale: 31/07/2016

Theme: Leadership, Governance and Management

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

There was no annual review of the quality and safety of care and support in the designated centre.

21. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

An annual review of the quality and safety of care and support in the designated centre has commenced and will be available in the designated centre on 30th May 2016

Proposed Timescale: 30/05/2016

Theme: Leadership, Governance and Management

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

Unannounced visits to the designated centre had not been carried out.

22. 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:

The provider nominee will conduct an unannounced inspection in the designated centre on the 14th April 2016.

A documented audit report of findings will be available to view in the designated centre.

Proposed Timescale: 30/04/2016

Theme: Leadership, Governance and Management

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

The 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 were not effective.

23. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

The Regional Director of Nursing, the Clinical Nurse Manager and Person in Charge will attend Supervision training on 10th May 2016.

All staff of the designated centre will receive supervision by 31st July 2016

Proposed Timescale: 31/07/2016

Theme: Leadership, Governance and Management

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

Staff were not being adequately facilitated to raise concerns about the quality and safety of the care and support provided to residents.

24. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

The Clinical Nurse Manager and the Person in Charge will attend Supervision training on 10th May 2016. 10th May 2016

All staff of the designated centre will receive supervision by 31st July 2016

There is a Clinical Nurse Manager in place full time in the designated centre which offers an opportunity for staff to communicate concerns directly.

The provider Nominee will carry out an unannounced inspection in the designated centre on 14th April 2016.

Proposed Timescale: 31/07/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was no planned and actual staff rota of the week the inspection took place.

The staff rota from previous weeks did not identify the start and finish time of working shifts.

25. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

A comprehensive duty roster in excel format (to document planned and actual rosters) will be implemented in the designated centre. The roster will be managed on a weekly basis by the Clinical Nurse Manager and will include start and finish times.

Proposed Timescale: 22/05/2016

Theme: Responsive Workforce

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

It was not evident the provider was ensuring that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents.

26. 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:

A review of the roster will be carried out by the Person in Charge and the Clinical Nurse Manager and staff in the designated centre to assess staffing levels / requirements appropriate to the designated centre, based on the assessed needs of the residents.

A review will be undertaken by the Clinical Nurse Manager of all training requirements in the designated centre based on the assessed needs of the residents. Training needs will be identified and actioned by the Clinical Nurse Manager and the person in charge.

The agency staff member in the designated centre has achieved mandatory and statutory training.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

Staff were not appropriately supervised.

27. Action Required:

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

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

The house manager and Person in Charge will attend Supervision training on 10th May 2016.

Supervision meetings will be conducted by the Regional Director of Nursing with the Person in Charge with a view to increasing the skills and identifying skills gaps required to manage the designated centre.

Supervision meetings will be conducted by the Person in Charge with the Clinical Nurse Manager with a view to increasing the skills and identifying skills gaps required to manage the designated centre.

Supervision meetings will be conducted by Clinical Nurse Manager with the staff of the designated centre with a view to increasing the skills and identifying skills gaps required to operate and manage the designated centre.

A schedule has been drafted for the Person in Charge to meet with the manager in the designated centre weekly commencing 13th April 2016 to provide further monitoring.

There is a house manager now in place full time in the designated centre which offers appropriate supervision of staff.

Proposed Timescale: 31/07/2016

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 policies and procedures required review as they were not centre specific and there was an inadequate system to ensure staff read, understood and agreed to adhere to the policies and procedures.

28. 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:

There is a Clinical Nurse Manager now in place in the designated centre and has ensured that the policies required by schedule 5 of the regulations are accessible.

The Clinical Nurse Manager continues to ensure that staff read, understand and adhere to the policies and procedures of the designated centre.

A process has commenced to review the schedule 5 policies which have been identified as requiring an update in the designated and this will be completed by 31st May 2016.

An on-site documentation review in the designated centre will take place on the 29th April 2016.

Proposed Timescale: 31/05/2016

Theme: Use of Information

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

Some of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 had not been implemented in the centre.

29. Action Required:

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

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

The Clinical Nurse Manager in the designated centre will ensure that the new complaints policy to be developed by the 18th May 2016 and the existing medication policy will be implemented in the designated centre.

Proposed Timescale: 30/05/2016

Theme: Use of Information

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

The directory of residents did not include the date on which some residents first came to reside in the designated centre.

30. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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 directory of residents will be updated to include all information required under schedule 3, relevant to the directory of residents, to include the date on which residents first came to reside in the designated centre.

Proposed Timescale: 31/05/2016

Theme: Use of Information

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

Some or all of the records of the information and documents in relation to staff specified 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 had not been put in place for staff working in the centre.

31. Action Required:

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified 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 .

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

The Person in Charge, the Clinical Nurse Manager and the staff working in the designated centre are undertaking a review of all staff files to ensure that they include the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Proposed Timescale: 15/06/2016