

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Peamount Healthcare ID Community Based Service
Centre ID:	OSV-0003504
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Peamount Healthcare
Provider Nominee:	Suzanne Corcoran
Lead inspector:	Anna Doyle
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	28
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was unannounced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
08 February 2017 09:45	08 February 2017 20:15
09 February 2017 09:30	09 February 2017 20:45

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the third inspection of the designated centre. This was an unannounced inspection to follow up on actions from the previous inspection carried out in the centre in August 2016 and to inform a registration decision. In response to the high level of non compliances found at the last inspection the provider was called to a meeting in HIQA offices, during which the provider assured inspectors that they were taking proactive measures to address the non compliances. As part of the application to register, the provider is required to submit documents. The lease agreement for two properties had not been submitted at the time of this report.

Description of the service:

This centre is operated by Peamount Healthcare and is divided over three community locations in County Dublin. Two of them are located close to each other and the

other one is approximately 11 kilometers away.

The first location can accommodate 16 residents and comprised of two, one bedroom apartments, six two bed apartments and one three bedroom apartment. On the day of the inspection there was one resident receiving respite care from another unit within the designated centre

The second location can accommodate 10 residents and consisted of four apartments. Three of these apartments were three bedroom apartments located on the ground floor and one apartment was a one bedroom apartment located on the first floor. On the day of inspection, one resident was receiving respite care in the centre due to major renovation works that were being completed in another designated centre belonging to Peamount.

The third location could accommodate five residents and comprised of two semi detached houses. One the day of the inspection there were two vacancies in this unit as one resident was currently receiving respite care in another location that was part of the designated centre.

Two of the locations are owned by Peamount Housing association and one location is leased from a third party.

The centre provides care to both male and female residents who have an intellectual disability, some of whom have medical needs, mobility issues and some behaviours of concern. The model of support is based on assisted community living using the social care model. However, nursing staff were now employed in the centre. At the last inspection nursing support was available from a community team that visited the centre on a needs basis.

In addition to this there is nurse on call system in place from a nearby campus operated by Peamount for any out of hour's concerns or advice.

How we gathered evidence:

The inspector met with seven residents to ask about what it was like living in the service and about the quality of services provided. All of the residents said that they were happy living there. Some said that they would like more opportunities to engage in community activities in the evening time, particularly in the summer time. Residents said that they were very happy with the staff in the centre, but would like staff to spend more time with them. They spoke about activities they were involved in that included attending day services, going shopping, attending a local community group and future holidays they were planning.

Some residents were unable to express their views on the quality of services in the centre. In response, the inspector observed practices, reviewed personal plans and observed interactions between staff and residents. A number of staff were met and other documents were reviewed including risk assessments and financial records.

A new provider had been appointed since the last inspection to the centre. The person in charge was present throughout the inspection. They attended the feedback

meeting. No senior personnel were available to attend the feedback meeting.

The inspector visited two of the locations, the third location had been visited at the last inspection. The person in charge was asked to submit information relating to an action from the last inspection relating to this property. This was submitted and the inspector found that the action had been addressed.

Overall judgment of our findings:

Some good practices were observed in the centre, that included the review of incidents in the centre and staff treated residents with dignity. Residents appeared to know the staff well and spoke about them in a positive manner. The inspector would also like to acknowledge that a significant event had occurred in the centre since the last inspection and that this may have contributed in some part to some of the actions not progressing.

However, notwithstanding this, the inspector found that while some improvements had been made in the centre, eleven of the actions from the last inspection had not been implemented. Major non compliances were found in four of the outcomes inspected against. These included residents' rights, social care, medication management and governance and management. While some improvements had been made to the recording systems in place for residents' finances, significant failings were found regarding residents being charged for equipment that should have been covered under their contract of care.

There had been little progress made under social care needs since the last inspection. The inspector found that medication management practices in the centre were not guided by appropriate policies and procedures and on the first day of the inspection, the inspector had to request assurances from the person in charge around practices in the centre.

There were no clear lines of accountability for two areas of service provision and the person in charge had no oversight over some staff employed in the centre. The inspector found that the systems in place to monitor and review the quality of care in the centre were not effective.

Moderate non compliances were found in four of the outcomes under communication, health and safety, healthcare needs and workforce. The inspector found that staffing levels were not organised around residents assessed needs and residents could not access evening activities in the community as there were insufficient staffing levels on duty. Two of the outcomes were substantially compliant under documentation and safeguarding. The actions at the end of this report outline the improvements required.

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

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

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

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

Findings:

The inspector found that two of the actions from the last inspection had not been implemented and improvements were still required under the management of complaints and the systems in place to manage residents' finances in the centre.

At the last inspection an external auditor had been commissioned to review residents' finances in one unit of the centre. This had been part of the provider's response to a notification that had been submitted to HIQA regarding residents' finances. The report from the audit had not been finalised at that time and was submitted to HIQA subsequent to the last inspection.

The findings of this report confirmed that significant amounts of money belonging to residents could not be accounted for. Some of the money that could not be accounted for was down to poor recording practices. For example, there were no receipts to validate monies spent. However, it was concluded that some was down to misappropriation of residents' finances. In response, the provider had committed to refund the monies to all residents affected and the inspector was shown records demonstrating that this had been completed. Relevant authorities had also been notified. The inspector also saw a record of where the nature of the notification had been made into a user friendly document for residents so as to explain the nature of events to them.

There was a finance policy in place that had been reviewed, which included the removal of information that may compromise residents' rights in the centre. This had been an action from the last inspection

A sample of financial records viewed found that two residents were required to pay additional costs for services that were outlined in their contracts of care as been included in the fees charged to them. For example, the contract of care stated that services provided would include the provision of hearing aids and appliances as part of the fees paid by residents. Yet the financial records viewed by the inspector found that one resident had paid for a hearing aid and the other resident was paying for specific aids themselves.

Since the last inspection a more effective system had been introduced to record residents' finances in the centre. All receipts were recorded and numbered by the staff that had supported the resident to spend their money. The key worker staff that supported the resident was then responsible for ensuring that the records each month were reviewed and reconciled against the residents' bank statements.

The inspector found that for the most part this was completed. However, improvements were still required to ensure that the amounts were recorded correctly and that there was a clear transparent system in place for when residents were required to share bills.

For example, the inspector saw from records viewed that a grocery bill for two residents had not been divided equally and there was no clear rationale for this. There were also no records to confirm whether one resident had paid another resident for half of a utility bill that had been paid in full by one resident. The inspector was assured from additional information submitted to HIQA that this was addressed

In addition, the person in charge also showed the inspector a sample template that included a breakdown of expenses for residents. This would form part of the plan to address transparency around residents sharing bills in the centre.

Monthly expenditure forms for residents were signed off by the person in charge and audits were now completed by personnel from the finance department. An audit had recently been carried out in the centre and actions from this had been implemented into practice. For example, one resident had no financial assessment in place and this had been completed.

The inspector found that the two residents who were paying for additional staff (personal assistants) from an external provider at the last inspection were no longer paying for this service. Both residents informed the inspector that they were happy with this outcome.

There were no open complaints on the day of the inspection. The inspector was informed that the last complaint raised at the inspection had been dealt with. However, the inspector found that one resident had raised issues with one area of service provision in the centre. Records were viewed by the inspector demonstrating that the person in charge had advocated for the resident so as to resolve the issue.

However, this issue had not been dealt with under the complaints policy of the service and while some actions had been taken, a full resolution had not been reached for this resident. The nature of this complaint is not discussed in this report to protect

anonymity.

Intimate care plans were in place for residents. However, they were not detailed enough to guide practice. This had been an action from the last inspection had not been progressed.

Staff were observed to treat residents with dignity and respect. For example, all staff knocked on residents doors before entering their apartment or bedroom.

However, the provider had stated as part of the action plan that the induction training for new staff would include the importance of upholding resident's dignity and respect. The person in charge could not confirm whether relief staff who had been newly employed in the centre had received induction training prior to commencing in the centre.

The inspector was shown records of an induction sheet that was to be completed for all new staff including agency in the centre which outlined the importance of respecting resident's dignity. However, this had only been completed for three staff in the last year which was not reflective of the amount of new/agency staff employed in the centre over the same timeframe.

Judgment:

Non Compliant - Major

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

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

Findings:

The inspector found that one of the actions from the last inspection had not been fully implemented and improvements were still required.

Communication passports were in place for residents in the centre. However, some of them had not been updated since the last inspection as outlined in the action plan.

The inspector also found that one resident's communication plan was not adequate to guide practice for staff. For example this resident had a picture book in place to assist with their communication, but there was no interventions in place around the use of this and other non verbal skills used by the resident in order to guide practice.

<p>Judgment: Non Compliant - Moderate</p>

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

Findings:
The inspector found that there was a policy in place for admissions to the centre and that residents had service agreements contained in their personal plans.

Residents now had contracts of care in place in the centre. The contracts set out the services to be provided and the fees charged to residents. Some of the contracts had been sent to the residents' representatives as appropriate to be signed.

The admission policy for the centre had recently been updated. The centre was not accepting any admissions from external agencies. However, admissions were considered from other designated centres in Peamount.

Judgment:
Compliant

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

Theme:
Effective Services

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

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

Findings:

The inspector found that one action had been completed since the last inspection. However, the other actions had either not been implemented to a satisfactory level or were only in progress. Significant improvements were still required so as to ensure that all residents' needs were assessed, supports were in place to meet those needs and identified needs were appropriately reviewed and monitored to improve outcomes for residents in the centre.

A sample of personal plans were viewed in two of the units in the centre. The inspector found that while a new personal and social care assessment of need had been devised by the organisation, it had only been implemented in three personal plans in one unit. In the other unit it had not been implemented at all and the assessment of need remained unchanged in this unit since the last inspection.

On review of this new assessment the inspector found that it was not detailed enough to reflect residents actual personal and social care needs. The inspector was informed by staff that this assessment had not been implemented as staff were awaiting training in this area.

In addition, to this the inspector was informed that a new healthcare assessment of need was being implemented. The inspector was informed that this was only in the process of being completed for one resident and had not been implemented in other areas of the centre.

Nursing staff were responsible for the completion of healthcare assessments and healthcare assistants were responsible for completing the social and personal care assessment. However, there was no process in place for these staff to meet to ensure that the assessment of need was completed holistically and reviewed appropriately to reflect changing needs.

At the last inspection there were no structured plans in place around residents' assessed needs and it was not clear how life skills were taught in the centre or the supports necessary to maintain or enhance these skills. This action had not been implemented and it remained unclear what supports residents required on any given day to support them in activities of daily living.

At the last inspection some residents' plans had not been reviewed yearly or sooner. The inspector found that some of the actions under this had been implemented. For example, multi-disciplinary team meetings were regularly held for residents.

However, the inspector found that the review was not meaningful and did not improve outcomes for residents as actions were not always implemented. For example, one resident had requested a change in how their details were recorded and this had not been implemented. This was discussed with the person in charge and is not detailed in this report to protect anonymity.

In addition, the inspector found that residents care needs were reviewed at staff meetings, however this was not always reflected in the personal plan.

No annual reviews had occurred in the centre since the last inspection that included the resident or their representative where appropriate.

One resident had recently transitioned to one unit of the centre and two other residents were receiving respite care in the centre on the day of the inspection. The residents appeared very happy living in the centre. One resident, receiving respite care from another location in the centre told the inspector they were very happy with this move and had requested to move to this area on a permanent basis. This was currently under review with the relevant personnel.

The inspector viewed the transition plan for the resident who had recently transitioned to the centre. The transition details were recorded through multi disciplinary meetings. The records demonstrated that some good practices were followed in relation to this.

For example, the resident visited the centre a number of times, and had phased sleepovers prior to their admission to the centre. Family members had the opportunity to visit the centre and an occupational therapist had completed an assessment regarding support levels required in the new placement.

However, some areas of need were not discussed as part of the transition. For example, healthcare needs and there was no involvement from nursing staff in this process. The inspector did speak with a staff member around this residents needs and they were familiar with their healthcare needs.

In addition, it was also not clear what the rationale was for this resident transitioning to the centre and staff could not verify this information either.

The inspector was informed that residents residing in the centre had been consulted about residents moving to the centre. However, there were no records to demonstrate that this consultation had taken place and one resident stated that it had not been discussed with them.

There were records to demonstrate that residents receiving respite had some of their personal records reviewed as part of their transition to the centre. And while staffing levels had been increased to support one resident with their transition, this had stopped after one week and no review had taken place to ensure that this residents needs could be met with the current staffing levels in the centre.

For example, there were times during the day when this resident would remain in the unit unsupervised and this had not been appropriately assessed or reviewed.

The inspector was also informed that a decision had been made for this resident to move permanently to the centre but there were no records to demonstrate why this decision had been made. The person in charge could not verify this either.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The inspector found that the actions from the last inspection had been implemented and that the location, design and layout of the centre were suitable for the stated purpose of the centre.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The inspector found that the actions from the last inspection had been implemented with the exception of two which related to fire doors in one area of the centre and risk assessment training for staff. Improvements were also required in risk management in the centre.

The system in place to review incidents in the centre had improved since the last inspection. The person in charge had developed a new format whereby all incidents occurring in the centre were followed up. This included recording trends in incidents and identifying whether additional control measures were required to mitigate future risks. The person in charge signed off on all incidents once they were assured that appropriate

control measures were in place.

A risk register was in place in the centre and the person in charge was regularly reviewing and updating this. However, some of the information contained in this register contained control measures for individual residents assessed needs. This information was not always contained in the personal plan. There were no risk assessments completed on residents' plans for when they were unsupervised in their apartments.

A fire drill had taken place in one unit in the centre since the last inspection. The records indicated that there were no issues identified and the drill had been completed when only one staff member was present in the unit. Personal emergency evacuation plans had been updated and staff spoken to were clear about evacuation procedures in place.

Staff had completed training in fire safety. However, there were no records to indicate whether relief staff had completed this training. Staff had also not completed training in risk assessment training as outlined in the last action plan.

There was one fire evacuation aid in the centre and staff stated that they had not received up to date training in this area. However, on review the inspector found that this aid was no longer being used in the centre. This was confirmed by the person in charge.

There were no fire doors in two houses that were part of the centre in order to contain fire.

There had been improvements in the cleanliness of the centre, although some areas still required attention. This was discussed with the person in charge.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The inspector found that the actions from the last inspection had been implemented, but further improvements were required in the use of one restrictive practice in the centre and staff training.

Since the last inspection all permanent staff employed in the centre had completed safeguarding training. However, a number of new relief staff and another staff member employed under a community employment scheme had not completed this training. The person in charge had organised for one of these staff to complete this training by the end of the inspection and intended to schedule the other staff at the next available dates.

Staff spoken with were knowledgeable about what constitutes abuse and were aware of the procedures to follow in such an event. Residents said they felt safe in the centre and would report concerns to staff if they were unhappy.

At the last inspection two restrictive practices were in use in the centre. One of these practices relating to a door alarm had been discontinued. The other potentially restrictive practice was a bedrail and the resident in question had requested this. While there were no records to demonstrate this, the inspector spoke with the resident who confirmed this.

The inspector was informed that a bed alarm was in place for a resident in the centre. However, it was not clear why this was in place; the staff and person in charge said that it was to alert staff in the event of the resident requiring assistance due to epilepsy or falls. The rationale for its use was not documented, risk assessed or reviewed.

Behaviour support plans were not reviewed as part of this inspection.

Judgment:

Substantially Compliant

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

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

Findings:

The inspector was satisfied that the person in charge had followed up on the actions from the last inspection.

A record of all incidents occurring in the centre were maintained and where required notified to HIQA.

Judgment:

Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

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

Findings:

The inspector found that the action from the last inspection had been implemented.

Residents were engaged in activities internal and external to the centre. Residents spoken with said that they had opportunities to attend day services and spoke about going on holidays this year, going shopping and accessing other community activities. Residents did say that they would like more opportunities to access evening activities outside of the centre.

One resident who met with the inspector had stated at the last inspection that they were lonely in the centre. However, they said that this was no longer the case and were very complimentary of all of the staff in the centre. They stated that they had been provided with opportunities to access community groups in their area but had declined this.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

The inspector found that while residents were supported to achieve good health, there were deficiencies in the documents contained on residents personal plans to support whether all identified needs were being met. In addition, the actions from the last inspection had not been fully implemented.

A healthcare assessment of need was not in place on residents personal plans.

In the absence of a detailed healthcare assessment, the inspector reviewed residents' medication prescription sheets and aspects of their personal plans. There was evidence of detailed support plans in place for some residents assessed needs. For example, the management of diabetes.

Staff spoken with were knowledgeable about residents healthcare needs and two residents were knowledgeable about their healthcare needs when they met with the inspector. However, there were no support plans in place for some identified needs to guide practice. This had been an action from the last inspection.

In addition, there were no records to demonstrate that one resident's decision making capacity was considered as part their healthcare treatment plan. This was discussed with the person in charge.

In some records viewed there was no clear link between some interventions, as differing support requirements were outlined in some interventions. For example, a speech and language assessment for one resident stated that supervision should be in place at all times during meals. However, the risk assessment in place stated that supervision should be in place where possible. This was consistent with findings from the last inspection.

Residents had access to allied health professionals in a timely manner. On the days of the inspection residents were being supported by staff to attend appointments with allied health professionals.

Mealtimes were not observed as part of this inspection.

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):

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

Findings:

The inspector found that the centre did not have appropriate and suitable practices in place relating to medication management in the centre. In addition, one of the actions from the last inspection was not implemented regarding medication protocols.

There was a policy in place for the administration of medication in the centre, that had recently been reviewed. However, the policy did not reflect the practices in the centre. For example, the policy stated that healthcare assistants trained in the safe administration of medication could only administer as required (PRN) medication from medications dispensed in blister packs. This was not the practice in the centre.

In addition, since the last inspection, HIQA had been notified of changes in medication practices in the centre and at the time assurances had been given that systems were in place to address this. On the first day of the inspection, the inspector was informed that nursing staff were now employed in the centre and were responsible for medication practices in the centre. They reported to a clinic nurse manager and up to recently were employed from 8am to 8pm in the centre every day. Non nursing staff who had been trained in the safe administration of medication were administering medications to residents at night time.

However, staff said that this arrangement had recently changed without any staff consultation and that some days nursing staff were now rostered to finish at 4.30pm. This information was confirmed by the person in charge. The reduction in nursing staff hours was due to current nursing vacancies that were not being filled.

When the inspector asked staff to confirm who was responsible for the administration of medication between 4pm and 8pm in the centre when nursing staff were not available they were unclear who this was. They said that under the new policy they could not administer PRN medications to residents.

The inspector spoke to the person in charge who confirmed that the health care assistants were responsible for this. However, given that staff were unsure, the inspector requested that this be discussed with the staff on duty and provide written assurances that this was the practice in the centre. This was received on the first day of the inspection.

It was also not clear who had oversight over medication practices in the centre. For example, the person in charge managed medication errors in the centre and had oversight over some practices relating to non nursing staff. The clinic nurse manager who had oversight over the nursing staff and who the nurses reported to, did not have any oversight over medication practices in the centre, apart from the fact that they administered medication in the absence of nursing staff.

In addition, while medication errors occurring in the centre were managed by the person in charge, there were no other systems in place to monitor safe medication practices in the centre. And there were no records to demonstrate that the person in charge and the clinic nurse manager met to discuss practices.

For example, medication errors were recorded on a medication event report form and reviewed by the person in charge. There had been a number of medication errors in the centre since the last inspection. The records viewed demonstrated that most issues were being followed up.

However, the inspector found that a control measure relating to transcribing medications had not been fully implemented as all staff which included the clinic nurse manager were not aware of the control measure and the policy review had not included this update.

A sample of prescription sheets and administration sheets were viewed and were found to contain the appropriate information. However, there were no PRN protocols in place for some prescribed medication. One PRN protocol for a resident was unclear as it did not state what staff should do if they were not trained to administer the prescribed medication. Staff spoken to were clear they would report it to the nurse on call out of hours.

Medications were securely stored in the centre and a locked fridge was available for prescribed medications. Records were maintained to chart fridge temperatures on a daily basis. There was a system in place to record medications received in the centre. However, it did not include prescribed as required medications.

Some residents self administered medication in the centre. A risk assessment form had been completed and from the sample viewed they were detailed enough to guide practice. One minor improvement was required in this area and this was amended by staff on the day of the inspection.

Judgment:

Non Compliant - Major

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector found that the actions from the last inspection had been implemented. Some minor improvements were required, however they were completed and submitted to HIQA the day after the inspection.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector found that some of the actions from the last inspection had not been fully implemented and significant improvements were required in the management structures in the centre to ensure clear lines of accountability were in place for all areas of service provision. In addition, improvements were required so as to ensure that there are management systems in place to ensure that the services provided are safe, appropriate to residents needs and effectively monitored.

The inspector found that there were no clear lines of accountability for some services provided in the centre. For example, as outlined in this report, it was not clear who had overall responsibility for medication practices and the management of residents' healthcare needs in the centre.

Staff spoken with, which included nursing staff and health care assistants - said that nursing staff were responsible for medication management and residents' healthcare needs. It was unclear therefore how the person in charge had oversight over all areas of service provision in the centre as the nursing staff reported to a clinic nurse manager and not to the person in charge. The clinic nurse manager who met with the inspector confirmed this and also stated that they reported to a person participating in the management of the centre and not the person in charge.

In addition, there were no meetings held with the person in charge and the clinic nurse manager in the centre to discuss and review residents' needs and medication practices

in the centre.

The person in charge was suitably qualified and fulltime in their role. They were supernumerary in the centre. They were interviewed at the last inspection in the centre and were found to be knowledgeable of the regulations. They had been in the role for six months. Staff said that they felt supported by the person in charge.

The person in charge reported to the acting director of health and social care, who had not been notified to HIQA as a person participating in the management of the centre. This person participating in the management of the centre reported to the provider nominee. However, there were no meetings taking place with the person in charge and their direct line manager in order to review the quality of care in the centre.

A new provider nominee had been appointed to the service and staff confirmed that they had visited the centre since taking up the post.

Staff meetings were being held more regularly in the centre and supervision had started with some staff. The inspector was shown notes that the person in charge had taken at these meetings, which had not yet been formally drafted. The notes included a variety of topics one of which included training needs. The person in charge intended to set a schedule for all staff to have this going forward. This had been an action from the last inspection.

However, the person in charge was not responsible for the supervision of any nursing personnel in the centre and the clinic nurse manager confirmed that they did not formally supervise any of the nursing staff in the centre.

An unannounced quality and safety review had not taken place since the last inspection. At the last inspection an annual review had been completed in April 2016 which did not include consultation with residents or family members. The inspector acknowledges that this action had not yet reached the time frame for completion as the next annual review was due in April 2017.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

The inspector found that some of the actions from the last inspection had not been implemented under staff training in the centre and improvements were required to ensure that staffing levels in the centre were organised around residents needs.

As part of the actions from the last inspection the provider had commissioned a review of staffing levels in the centre. The findings of this had been brought to the HSE.

However, since the last inspection, additional nursing staff were employed in the centre, which increased the staffing compliment in the centre. The inspector found that with this addition of staff, that the staffing was not organised around residents assessed needs.

For example, with the addition of nursing staff four staff were on duty in one area of the centre during the day and only two staff were on duty from 8pm - 12am in this area and after that there was only one staff on duty.

In another area of the centre, with the addition of nursing staff there were 4 staff on duty during the day and only one staff on duty from 8pm onwards. Some days nursing staff completed a 12 hour shift in the centre and some days they did not.

In the absence of nursing staff, health care assistants were required to take over managing the health care needs of residents, however there were no clear protocols in place to guide them in some areas of need.

In addition, some mornings nursing staff did not start work until 9am, this meant that another staff member had to administer morning medications leaving only two staff to support residents in four apartments even though staff informed the inspector that all residents required supports in the morning time.

There were no opportunities for residents to do activities in the evening time if they wished as there was not enough staff on duty. Some residents spoken with said that they would like more activities in the evening time. One resident in the centre required two staff to support them when out in the community and informed the inspector that they had not been out at any social events in the evening time in about two years.

Staff had not received the training in diabetes management as part of the action plan from the last inspection. The inspector also found that health care assistants were required to check vital signs for residents as part of their healthcare needs and while the staff member spoken to was clear about what to do when asked by the inspector, there were no records to demonstrate training in this for staff.

Records were made available to demonstrate that staff employed from external agencies had been Garda vetted and had completed mandatory training, with the exception of one staff who had not completed safe guarding training and new relief staff who had

not yet completed any training mandatory training.

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):

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

Findings:

The inspector found that the actions from the last inspection had been implemented. However, improvements were required in one policy under Schedule 5 of the regulations and documentation.

There was an admission policy in place in the centre, that contained procedures in place to guide practice for staff. However, it did not include the procedure to follow for respite admissions to the centre. The inspector acknowledges that this had been raised for discussion at a managers meeting this month and it had been agreed to review this policy.

The inspector found from a review of records stored in the centre that some records were illegible and some did not have the dates recorded on them.

Judgment:

Substantially Compliant

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:

Anna Doyle
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 Peamount Healthcare
Centre ID:	OSV-0003504
Date of Inspection:	08 February 2017
Date of response:	05 May 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Intimate care plans were not detailed enough to guide practice.

There were no records to demonstrate that relief staff had received induction training that included the importance of upholding resident's privacy and dignity in the centre.

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

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

Intimate care plans will be reviewed and updated to ensure that sufficient detail is included to clearly guide practice.

All newly employed staff members will receive both organisational and local induction which includes the importance of respecting the dignity of the residents.

Proposed Timescale: 30/06/2017

Theme: Individualised Supports and Care

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

Two residents were paying for services that were outlined in their contracts of care as being included in fees charged.

2. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

The Person in Charge will ensure that residents do not pay for services that are outlined in their contracts of care as being included in the fees charged to them.

Where appropriate, reimbursement has been sought for residents who have paid for items/services that are outlined in their contracts of care as being included in the fees charged to them.

Proposed Timescale: 31/05/2017

Theme: Individualised Supports and Care

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

One issue raised by a resident around the provision of services had not been dealt with under the organisations own complaints policy.

3. 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:

Supports and training have been put in place to resolve this issue for the resident so that they will receive the service they require in accordance with their needs. The resident is aware of the additional supports and is satisfied with what has been put in place.

The additional supports will be reviewed in two weeks by the Social Work department to ensure that they are effective.

Proposed Timescale: 27/03/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Some residents' communication plan had not been updated since the last inspection.

There was no communication intervention in place around the use of a picture book and other non verbal skills used by one resident in order to guide staff practice.

4. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

Out of date communication passports are being updated currently by the Speech & Language Therapy (SLT) department, Person in Charge and individual residents' keyworkers.

The SLT department has developed a Communication Tips Sheet for use by the staff team that support this resident and also compiled an up to date summary report relating to the resident. The SLT Manager will also meet with the resident's keyworker on March 26th to review the communication environment where the resident lives to assess if additional supports or aids are required.

Proposed Timescale: 30/04/2017

Outcome 05: Social Care Needs

Theme: Effective Services

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

A comprehensive assessment of need had not been completed for all residents in the

centre to include all social care needs, healthcare needs and activity of daily living needs.

There was no link between the nursing staff and healthcare assistants to complete the assessment of need for residents in a holistic way.

5. Action Required:

Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

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

A process to implement a more effective system of assessing residents' needs (social care, healthcare and activities of daily living) is in place and ongoing since January 2017.

The nursing team and the frontline Health Care Assistants (HCAs) will conduct a weekly review of the healthcare, nursing and medical needs of each resident in each location in the designated centre.

The Person in Charge and the Clinical Nurse Manager responsible for the community nursing team will meet on a weekly basis to ensure that the residents' needs are being assessed in a holistic manner.

The community nursing team will be invited to the scheduled staff team meetings in each location in the designated centre, so that discussions relating to the residents' needs can be carried out in a collaborative manner.

Proposed Timescale: 30/04/2017

Theme: Effective Services

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

There were no support plans in place for some residents assessed needs.

There was no structured plan in place to ensure that residents were supported with independent living skills as appropriate to their need.

Some interventions had differing support needs outlined in residents' plans.

6. 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:

Support plans will be put in place for all residents' assessed needs.

The Person in Charge will work with the Occupational Therapy (OT) department to introduce a system to identify residents' independent living skills and the supports required by the residents in these areas.

Residents' plans will be reviewed and updated to ensure that the supports outlined therein are appropriate to, and consistent with the needs of the residents.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

An annual review had not taken place for residents that included the resident and their representatives where appropriate.

7. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

An annual review which includes the resident and their representatives as appropriate will be completed.

Proposed Timescale: 30/09/2017

Theme: Effective Services

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

Actions agreed from multidisciplinary reviews in the centre were not always implemented.

8. 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:

Actions agreed at Multi Disciplinary Team meetings will be implemented in accordance with the timelines identified, and recorded in residents' personal plans to ensure implementation.

Proposed Timescale: 15/03/2017

Theme: Effective Services

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

There were no records to demonstrate why residents were transferring to the designated centre.

The transition plan for residents did not include nursing personnel from the centre.

There was no review of the supports some residents required in the centre in order to meet their needs.

9. Action Required:

Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

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

For all residents transferring to the centre, records will be kept which outline the reason why the resident is being transferred to the centre.

Transition plans for residents will be drawn up with the involvement of all relevant disciplines involved in the resident's care, as part of the ongoing Multi Disciplinary Team process.

A review of needs will be conducted by the appropriate multi disciplinary teams to identify the supports required by the residents.

Proposed Timescale: 30/04/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Staff had not completed risk assessment training.

Information contained in the risk register regarding individual residents assessed needs was not always contained in the personal plan in order to guide practice.

There were no individual risk assessments completed for residents who remained unsupervised in their apartments.

10. 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:

All staff members will receive Risk Assessment training.

The Risk Register will be reviewed and any information therein which relates to individual residents' assessed needs will be incorporated into their personal plans.

Individual risk assessments will be completed for all residents who spend time in their apartments unsupervised.

Proposed Timescale: 30/06/2017

Theme: Effective Services

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

There were no fire doors in two houses that were part of the centre.

11. 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:

Discussions will take place with the HSE to fund the installation of fire doors where required.

Proposed Timescale: 30/09/2017

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:

There were no records around the use of one environmental restrictive practice in the centre as outlined in the report.

12. Action Required:

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

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

This restraint is listed on the Restraint Register for the designated centre.
An environmental restraint rationale sheet has been completed for this occurrence.
The restraint is noted in the resident's personal plan under Mobility & Safety.

The restraint is notified to HIQA quarterly.
The restraint is reviewed every four months at a scheduled Multi-Disciplinary Team (MDT) meeting.

Proposed Timescale: 15/03/2017

Theme: Safe Services

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

Some staff had not completed safeguarding training in the centre.

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:

All staff members will receive training in safeguarding residents and the prevention, detection and response to abuse.

Proposed Timescale: 30/04/2017

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:

There were no records to demonstrate that one residents decision making capacity was considered as part their healthcare treatment plan.

14. Action Required:

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

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

Residents will be consulted, and their wishes/preferences documented, to ensure that their dignity and rights are upheld in relation to developing their personal plans.

Proposed Timescale: 15/03/2017

Theme: Health and Development

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

the following respect:

There were no support plans in place for some residents' healthcare needs.

Some interventions on residents plans have conflicting support needs recorded.

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:

Support plans will be developed for all residents' healthcare needs.

Residents' plans will be reviewed and updated to ensure that the supports outlined therein are appropriate to, and consistent with the needs of the residents.

Proposed Timescale: 30/04/2017

Outcome 12. Medication Management

Theme: Health and Development

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

The centre did not have appropriate and suitable practices relating to the administration of medicines in the centre.

The systems in place to monitor safe medication practices in the centre were not effective.

It was not clear who had oversight over medication practices in the centre.

The learning from one medication error had not been fully implemented into practice as staff involved were not aware of this practice.

16. Action Required:

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

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

A working group has been set up to review and update the current Medication Management policy and associated Standard Operating procedures (SOPs), to ensure that there is effective systems in place to monitor medication management, clarify issues such as overall oversight and the role of each discipline, and guide practice in the centre. The working group consists of Persons in Charge, Clinical Nurse Managers, Pharmacy representatives and frontline staff team members.

Learning from medication errors will be communicated clearly to all parties (at Team Meetings and reviews of associated documentation) involved in the management of medication in the centre to ensure that any identified actions are implemented into practice.

Proposed Timescale: 30/04/2017

Theme: Health and Development

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

There were no prn protocols in place for some as required medication.

One prn protocol did not guide practice in the centre.

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:

The Person in Charge and the nursing team in the centre are currently developing PRN protocols for all PRN medications for all residents, which will be individualised and guide practice.

Proposed Timescale: 30/04/2017

Theme: Health and Development

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

Staff were not clear who was responsible for the administration of medication in the absence of nursing staff on the day of the inspection.

18. 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:

Staff members on duty who have received Safe Administration of Medication (SAM) training are responsible for administering medication when there is no nursing staff on duty.

Proposed Timescale: 15/03/2017

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:

It was not clear who had overall responsibility for medication practices and the management of residents' healthcare needs in the centre.

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:

The nursing team in the centre reports to the Person in Charge in relation to medication practices and the management of residents' healthcare needs. The Person in Charge has overall responsibility for these areas.

The role is currently being reviewed and clear lines of accountability will be identified.

Proposed Timescale: 15/03/2017

Theme: Leadership, Governance and Management

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

A six monthly unannounced quality and safety review had not been completed.

20. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

A six monthly unannounced quality and safety review will be completed.

Proposed Timescale: 15/04/2017

Theme: Leadership, Governance and Management

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

the following respect:

Nursing staff in the centre were not supervised by the person in charge.

21. 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:

Supervision and performance management of the nursing team, in relation to non-clinical matters, quality and safety is the responsibility of the Person in Charge and will be carried out on a regular basis.

Supervision and performance management of the nursing team, in relation to clinical and professional matters, is the responsibility of the Clinical Nurse Manager and the Acting Director of Health & Social Care and will be carried out on a regular basis. Any issues arising from this will be addressed by the CNM and made known to the PIC.

Day to day support and development of the nursing team in the centre is provided on an ongoing basis by the Clinical Nurse Manager and the Person in Charge.

Proposed Timescale: 15/03/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staffing was not organised around residents assessed needs in the centre.

Some residents social care needs were not been met in the centre in the evening times.

22. Action Required:

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

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

The process of filling existing WTE gaps in the centre has begun. Additional frontline hours have been included on the roster in the centre since the inspection and this has resulted in an immediate increase in the meeting of social care needs for residents in the centre. Further additional frontline hours are planned for inclusion on the roster and will be implemented in the coming weeks.

Proposed Timescale: 15/03/2017

Theme: Responsive Workforce

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

Staff had not completed training on the assessed needs of residents. This included diabetes management and staff training in monitoring residents vital signs.

23. Action Required:

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

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

All staff team members will receive training in the assessed needs of residents, to include diabetes management, monitoring vital signs and any other areas identified as being relevant to their role.

Proposed Timescale: 30/04/2017

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 admission policy did not include the procedure to follow for respite admissions to the centre.

24. Action Required:

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

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

The admission policy is being reviewed currently with a view to including a section that deals with respite admissions to designated centres.

Proposed Timescale: 15/04/2017

Theme: Use of Information

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

Some records pertaining to residents care was not dated and some of the information recorded was illegible.

25. Action Required:

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

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

All records relating to residents' care will be dated and produced in a format that is clear and legible.

Proposed Timescale: 15/03/2017