Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003698
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Ronan O'Murchu
Lead inspector:	Mary O'Mahony
Support inspector(s):	Aoife Fleming; Mary Moore; Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	36
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 2 day(s).

The inspection took place over the following dates and times

From:	To:
31 March 2015 08:00	31 March 2015 16:00
01 April 2015 08:00	01 April 2015 19:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

Summary of findings from this inspection

This was the second inspection of this centre undertaken by the Health Information and Quality Authority (HIQA or the Authority). The first inspection took place on the 5 and 6 of November 2014. During this inspection, inspectors found that there were a number of serious and significant non compliances with the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. The centre had submitted an action plan to the Authority at that time which specified the actions that would be taken by the provider to address these non compliances.

This report outlines the findings of the second inspection of this centre which was an unannounced triggered inspection conducted on 31 March 2015 and 1 April 2015. The Authority had received unsolicited information in relation to continued deficits in the provision of healthcare, safeguarding and safety measures.

The centre comprised of eight houses in total and residential services were provided for up to a maximum capacity of 41 adults. Inspectors were informed that the majority of residents had significant intellectual disabilities and some residents also required additional significant supports in relation to behaviours that challenged. During this inspection, inspectors met with residents, relatives and staff members. They reviewed the premises, observed practices and examined documentation related to health and safety, residents' personal plans, accident and incident logs, policies and procedures and complaints. Many residents required a high level of assistance and monitoring due to the complexity of their individual needs. However, inspectors found that residents were not provided with a service that provided for their privacy and dignity or allowed opportunities for them to achieve their full potential. This will be addressed throughout the body of the report.

Inspectors noted that there continued to be serious and significant non compliance identified in this centre in relation to a number of fundamental and essential components of the requirements of Regulation. These included aspects of governance, staff supervision, staffing levels, safeguarding and protection and healthcare provision. The following list specifies the key findings of non-compliance in the centre:

-35 out of the total of 39 actions from the previous inspection had not progressed satisfactorily:
-adequate safeguarding practices were not in place for example, allegations of abuse reported to the centre had not been notified to the Authority and had not been investigated or satisfactorily recorded
-inadequate and inconsistent management of restrictive practices, no notifications of these had been made to the Authority
-lack of cleanliness in certain areas
-smell of urine from a physical restraint in use for a resident
-recorded incidents of unexplained bruising with no safeguarding actions
-no records of any complaints when there were significant concerns raised in the centre and a number of unsolicited concerns provided to the Authority
-poor management systems including no staff member having a job description
- staff member using an unsuitably raised voice and inappropriate tone of voice towards a vulnerable resident
-a lack of meaningful activities
-lack of suitable healthcare provision
-serious privacy and dignity issues
--continued gaps in training in relation to safeguarding practice, adult abuse, manual handling, complaints management, restrictive practices, and communication systems for certain residents.

By 19.30hrs on the second day of the inspection inspectors had issued a total of five immediate action plans due to the significant failings found on this inspection. In addition, inspectors had put the provider on notice that following the seriousness of the findings, the Authority would be further escalating it's monitoring of the centre in accordance with the Health Information and Quality Authority (HIQA) enforcement policy. Two immediate action plans were issued in the area of safeguarding and

safety, these are further expanded on under outcome eight in this report. A further two immediate action plans were issued in relation to healthcare needs: outcome 11 in this report and the fifth immediate action plan was issued in relation to poor governance and management arrangements which is covered under outcome 14 in this report. In addition, given the extent and nature of the non compliances identified, senior management agreed to suspend any admissions, including respite admissions, to the centre until further notice.

The action plan at the end of this report identifies where significant improvements were required to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

At the inspection feedback meeting inspectors identified the key findings listed above to the nominated provider, the person in charge, the clinical nurse manager and a second provider from the organisation. Reassurances were given to inspectors that the immediate action plans would be returned, with the actions to be taken specified, in accordance with the timeline set by the Authority. These were received by the Authority within the designated time frame. Further escalation action taken by the Authority included the issuing of an improvement notice with timelines set out for completion of the actions required. In addition, the provider was requested to provide weekly updates in relation to implementation and progress of the action plan to the Authority. To date the provider has fulfilled this requirement. Weekly updates have been provided to the Authority outlining actions taken to enhance staffing levels, to improve care planning processes, to safeguard residents' care and welfare, to provide training and to provide for supervision of staff. The provider stated that governance and management in the centre had been reviewed and changes made where the provider had deemed necessary.

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 following actions were not addressed since the last inspection:

-Residents did not have access to readily available advocacy services.

-Opportunities were not consistently provided for residents to participate in activities in accordance with their needs, interests and capacities.

-Each resident was not provided with appropriate care and support to achieve their full potential, having regard to the nature and extent of the resident's disability, their assessed needs and wishes.

-Records maintained of complaints were not always detailed as required by the Regulations.

The person in charge informed inspectors that most residents were assigned a staff member as a key worker and these staff members were responsible for updating assigned residents' personal care plans (PCPs). In the sample of PCPs that inspectors reviewed, individual resident's preferences were recorded. However, as found during the previous inspection, residents were not consistently offered opportunities to participate in communication or discussion about the running of the centre. The person in charge confirmed that there was no residents' committee and residents did not have access to readily available advocacy services. Nevertheless, one resident had attended advocacy training and advocacy training for staff was scheduled for 16 April 2015.

Staff, in general, were observed respecting residents' dignity by the manner in which they engaged with residents and they appeared to be familiar with residents' individual style of communication. However, there was robust evidence that residents' rights and dignity were compromised and they were not consistently provided with opportunities to achieve their full potential. Some residents were observed by inspectors either sitting or standing for long periods without much interaction and not engaged in meaningful activity during the day.

Examples of the lack of provision of privacy and dignity were as follows: one male resident with profound needs was accommodated in a house shared with five other residents one of whom was female. This residents' personal care plan outlined his daily routine and detailed that he had daily, sexualised behaviour which was part of his 'obsessional' routine. Inspectors saw documentation indicating that he would lie on the bathroom floor for long periods of time. Staff nurses and other staff members with whom inspectors spoke confirmed this. Inspectors found that he was not afforded protection or respect for his privacy and dignity by his current placement or environment. Other residents were negatively impacted by their observance of this behaviour and all other residents in the house were not afforded protection and respect for their privacy and dignity. In addition, another resident was seen by inspectors to be restrained for long periods of time in a chair, where he was clearly observed to be demonstrating that he was not happy with this arrangement, by his vocalisations and discontented facial expressions. When he was released and allowed down on the floor, as was his preference, inspectors noted that he was smiling and appeared content. An un-dated resident survey which had this resident's name attached, indicated that his preference was not to be restrained. Staff who spoke with inspectors confirmed that there were not enough staff to supervise him and he was not allowed on the floor without supervision. Furthermore, inspectors observed another resident who shouted loudly and repeatedly and appeared in significant distress. Inspectors observed that staff members were unable to de-escalate this behaviour or provide positive behavioural support. This further impacted negatively on the living environment for other residents in this house.

Personal plans were developed for residents. However, issues identified during assessment were not always implemented. For example, there was inadequate evidence that the programme of activities was implemented in line with the interests and hobbies of residents which had been identified on assessment. Where residents were supported with interests and hobbies it was often seen to be sporadic and inconsistent. Staff informed inspectors that they would like to take residents out more often to their preferred activities. For example, one staff member told inspectors that he was a key worker for one resident who liked to go swimming daily. However, he stated that due to unavailability of transport and adequate staff this activity was only available on a weekly basis.

Inspectors noted that each resident had furniture in their bedroom for storing their own clothing and personal possessions. There was evidence that appropriate processes were in place in regard to managing and protecting residents' finances. The records that inspectors reviewed in regard to residents' finances were clearly itemised.

There was a written complaints policy that outlined the process and actions to be taken in the event of a resident or their relative wanting to make a complaint. However, each resident did not have access to a complaints procedure that was in an appropriate format taking into consideration the nature of their disability. Records of complaints were not kept before January 2015, according to the person in charge. Inspectors requested to see records of incidents and accidents and any complaints which had been received. There were no complaint logs available in any house on day one of the inspection. These were available on day two of the inspection but had no complaints documented in these records. However, staff with whom inspectors spoke were not aware of the existence of these logs and did not have training in the management of complaints. The person in charge had written into each log that they had been audited in January and February. The audit showed that there were no complaints. However, a number of complaints had been made to the centre and these had not been recorded. Information on these complaints had been received by the Authority and this was brought to the notice of the provider and the person in charge. A clinical nurse manager with whom inspectors spoke explained that there was an informal procedure for dealing with complaints in each house. However, he confirmed that complaints logs had not been available in each house. None of these 'informal' complaints were documented in any records seen by inspectors.

Inspectors observed that the complaints process, the fire evacuation procedures, mealtime protocol and the resident's guide were displayed in the houses.

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):
No actions were required from the previous inspection.

Findings:
The centre had an up to date communication policy. However, staff were not trained in communication skills to meet the needs of residents in the centre. For example not all staff had training in picture exchange communication system (PECS) even though inspectors viewed care plans which recommended this communication approach for some residents. In addition, not all staff were trained in LAMH, a language system which some residents were capable of using.

Judgment:
Non Compliant - Moderate

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

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 following action had not been completed since the previous inspection:

-All residents were not consistently supported to develop and maintain links with the wider community.

Staff maintained records in individual resident's PCPs of any contact between residents and their relatives and records viewed confirmed that residents were facilitated to have visits from their relatives and friends as well as to go out overnight and stay with family members. Residents also had access to telephones to receive calls. However, it was noted by inspectors that not all residents had access to areas that were separate from their bedrooms to meet their visitors in private. Nevertheless, a new visitors' room had been developed in one of the houses since the last inspection and this was newly decorated and comfortable.

Staff confirmed and there was also written evidence in residents' PCPs that residents were involved in outings from the centre. However, not all residents were consistently supported to develop and maintain links with the wider community. As already addressed in outcome one, residents were not always facilitated to be involved in meaningful activities and this will be further discussed in outcomes five and 17.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Actions not completed or progressed since the previous inspection included:

-There was insufficient evidence that reviews of all residents' personal care plans (PCPs) were conducted in a manner that ensured the maximum participation of each resident, and where appropriate his or her representative/s, in accordance with the resident's wishes, age and the nature of his or her disability

-Personal plans did not positively impact on the lives of residents as adequate arrangements were not in place to meet each resident's assessed social care needs.

-Some residents' personal plans were not reviewed annually or more frequently if there was a change in needs or circumstances.

During this inspection and as already addressed in outcome one, each resident in the process of being assigned a key worker and a written PCP was in place which was designed to provide details about each individual resident needs and the support they required. Residents' preferences and overall goals for the year were set out, however, it was not clear from the documentation seen, who was responsible for supporting the resident in achieving the goals and what timeframe was involved. In addition, from the sample of PCP's reviewed by inspectors not all had been reviewed yearly or in response to residents' changing needs. For example one resident's behaviour had escalated and a corresponding review of the management of this had not been undertaken. In addition, inspectors did not see sufficient evidence that the PCP's had been developed in consultation with residents or their representatives.

Inspectors found that there was inadequate provision of staff training required to support residents to develop life skills and to communicate more effectively. For example, staff with whom inspectors spoke did not have training in a specific communication system, identified as required, for a resident. In addition, a resident had not been facilitated to attend an occupational therapist (OT) or speech and language (SALT) review appointment which had been recommended by SALT. In relation to other residents there were insufficient arrangements in place to meet assessed needs. For example, inspectors noted that residents had not received suitable or appropriate care in relation to behaviours that challenge, this was addressed under outcome one: Resident's rights, dignity and consultation and outcome eight: Safeguarding and safety. Inspectors also noted that clinical supervision was inadequate in relation to some residents' care. This was addressed under outcome 11: Healthcare needs and outcome 14: Governance and Management.

Some residents were provided with opportunities to take part in an activities programme delivered from an on-site recreation facility and inspectors observed a large group of residents attending a karaoke/ disco session during the inspection, as well as returning from walks and swimming sessions. Staff informed inspectors that external outings were

organised when possible and these included, for example, taking residents for a drive, going swimming or shopping, dining out, an Easter egg treasure hunt or attending movies. However, inspectors found that not all activities, identified as necessary to meet individual resident's social needs, were facilitated. For example, one resident's interests were listed as swimming, computers, I-pad, spins and finger-painting. However, this resident did not have these interests recorded in his activities plan. His weekend activities were recorded as 'ball playing and playing around the house'. This resident had been identified as requiring 'increased swimming at weekends'. Staff spoken with by inspectors stated however, that the pool was not available to residents at the weekend. In all houses there was evidence that residents with high physical, social, medical and psychological needs spent some periods of time without structured or meaningful activity or interaction. The person in charge stated to inspectors that the on-site activation centre was not "performing adequately" to meet requirements.

Activities both within the centre and external to the centre were limited, due to inadequate staffing. Staff members indicated that there was a shortage of transport, resources and suitably trained drivers to ensure that residents could be integrated into the community. Staff stated to inspectors that residents' short term goals, such as going swimming and going out to local restaurants for 'hot chocolate', were often not attained, due to staff shortages. One resident whose goals were signed as last reviewed in June 2014 had no evidence recorded that current goals were being achieved such as being enabled to use an I-pad and a DVD player. Inspectors noted that on 20 August 2014 the I-pad was recorded as "not available at present" and the DVD player was not working during the inspection. Nevertheless, staff were seen to allow him to access games and movies on their personal phones which was seen to give him enjoyment. An assessment of this resident's needs, seen by inspectors, stated that he was in danger of losing out on skills and new experiences without these supports.

Staff indicated a willingness to take residents to activities and those spoken with by inspectors were knowledgeable and enthusiastic about the residents' life stories, their care and their preferences. While not all staff had 'lamh' communication skills inspectors observed positive interactions between residents and staff who were trained in the system. The nominated provider, the person in charge and staff members confirmed that there was not a sufficient number or suitable skill mix of staff employed in the centre to meet the social needs of residents. Inspectors formed a view that this continued to have a serious effect on the provision of care to residents in the centre. The lack of suitable and sufficient staff was addressed under outcome 17.

Inspectors observed that one resident who attended an external day centre could not attend the centre recently as his transport chair was broken. There was no indication in the PCP as to the length of time that the chair was out of use. On the second day of inspection, inspectors saw that one resident had been prepared since early morning for his day in the external day care centre. He was transferred to his transport chair. He was obviously excited about the event. However, when the bus arrived later in the morning the resident was informed by the bus driver that the day centre was closed that day. This had not been communicated to the resident or to staff, in advance. Nevertheless, inspectors noted that staff were concerned about the impact that this would have on the resident and he was taken to the internal activation centre to provide some stimulus. Staff expressed to inspectors that this centre was 'not suitable' for him

due to his escalated needs but that the staff there would look after him.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Actions not completed or sufficiently progressed since the previous inspection were:

-Paintwork, tiling and grout in some of the toilet and washing facilities were in need of refurbishment. Paintwork, ceilings, chair coverings and cupboard doors in some of the communal areas were in a poor state of repair.

-Some areas in the houses were visibly unclean.

-Fridges and cooker doors required repair.

-There was not sufficient suitable storage available, as equipment was stored in living and visitor areas.

There were six houses on one campus and two houses off campus.

Six houses on the campus:

Six of the eight houses in the centre were purpose built and designed in pairs of houses, interlinking by a corridor. The houses were wheelchair accessible and had a bright and open layout. Residents had access to a safe outdoor area. Assistive equipment was available such as shower chairs, wheelchairs and specialised seating. However, equipment was not stored discreetly as storage space was inadequate, with equipment such as wheelchairs and assisted chairs seen stored in living areas and visitors' rooms. In addition, not all toilets and shower areas were fitted with 'grab-rails' to support those with mobility challenges.

All bedroom accommodation was single occupancy and as already addressed in outcome one, each resident had sufficient storage space for personal belongings. Rooms were

personalised and each had an individual wash hand basin. There had been improvements made since the last inspection such as new floor covering, enhanced cleaning hours and new mattresses. Toilet and washing facilities were communal and there was a sufficient number of these available. However, areas of the paintwork, flooring, tiling and grout were in need of repair in some of the houses. Each of the six houses had a kitchen, a laundry, dining room, communal lounge and sitting areas. However, as found on the previous inspection some appliances required repair for example, a damaged fridge in one house and a missing cooker door in another house. These had been identified by inspectors as requiring attention in November 2014.

Inspectors were informed that there was an increased allocation of three hours daily, on weekdays, for cleaning each house and that this service was provided by an external company. Inspectors noted that there was a substantial improvement in the level of cleanliness in comparison to the findings of the previous inspection. However, inspectors noted that a number of areas in the premises were still visibly unclean especially kitchenettes and some dining rooms. This will be addressed in detail under outcome 7: Health and safety and risk management.
In addition, inspectors noted that a number of the armchairs had torn coverings and mops and brushes were not stored adequately to prevent cross contamination.

Two Houses off the campus:

A further two houses provided single accommodation for two residents. Suitable bedrooms, toilet and washing facilities, kitchens, laundry facilities and living spaces were provided and the two premises were adequate and appeared clean. Alterations had been made to one house since the previous inspection and this had the effect of creating more internal space. There were external areas attached which residents could access. However, inspectors found that some of the outdoor areas adjacent to these houses were uneven and unsuitable for residents' needs. Inspectors saw evidence that a resident had fallen as a result of the uneven outdoor surfaces. In addition, one resident was not facilitated to use the large back garden. Furthermore, the gate on one house was inappropriately secured with a large chain and padlock. The provider undertook to replace this with a more suitable locking mechanism. There were CCTV cameras in place in one house. However, there was no sign to indicate the presence of such cameras and staff in this house informed inspectors that these cameras were not currently in use.

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

Findings:
Some actions not completed or progressed since the previous inspection included:

- some fire doors were kept open with door wedges or chairs
- inadequate locking mechanisms on doors to storage rooms and offices
- potential hazards in kitchens including unrestricted access to kettles, bread knifes and cookers as well as lack of a robust cleaning regime.
- unsecured storage of cleaning chemicals.

Findings on this inspection:

There was a health and safety statement in the centre for the organisation as a whole. However, inspectors were not satisfied that effective systems were in place for the management of all potential risks to residents. For example, there was a risk register that listed risks in the centre and actions to be taken to reduce risks of injury to any residents. However, there was no up-to-date documented evidence that the identified risks were being closely monitored as there were no dates or responsible person assigned to follow up on any identified hazards. Not all risks were identified for example, inspectors observed that personal protective equipment, such as latex gloves and plastic aprons, were located in kitchen drawers and some bathrooms in the centre. However, there was no risk assessment in relation to the choking hazard posed by the unrestricted access by residents to plastic aprons and latex gloves. At least one resident was known to have a tendency to swallow inedible objects. On the first day of inspection in one house the room where chemicals and cleaning products were stored was unlocked. Inspectors also observed that there were no grab rails in place in some of the residents' toilets. In addition, the risk management policy did not set out the controls for the four risks specified in Regulation 26.

As previously noted, the nominated provider, the person in charge and staff members confirmed that there was not a sufficient number and suitable skill mix of staff employed in the centre, to meet the identified needs of residents and ensure risks to them were mitigated. The impact of this lack of suitably trained and sufficient number of staff placed residents at significant potential risk of injury as many residents were at risk of self injurious behaviour. Consequently, residents required a high level of assistance, supervision and monitoring. While records were maintained of incidents involving residents, there was no evidence that robust arrangements were in place to frequently analyse and learn from incidents or adverse events in an effort to mitigate such risks to residents. In addition, staff informed inspectors that incident and accident books were not retained in each house. Such records were kept centrally in the administration office and staff were required to leave the house to record an accident or incident. Staff stated that the books might be in another house and staff would have to look for them which was unsuitable and unnecessarily time consuming.

Reports of incidents were provided weekly to the person in charge by the safety officer, However, the manager with whom inspectors spoke did not have access to these reports. It was not clear to inspectors whether the possible causes of multiple incidents involving residents were identified, many of which resulted in residents sustaining minor injuries as a result of assaults by peers. This will be further addressed in outcome eight:

safeguarding and safety.

Inspectors formed the view that residents were at potential risk of cross infection. Inspectors formed this view due to parts of the premises being unclean and inadequate practices and procedures in the centre, which were not consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. For example, inappropriate storage of uncooked meat in one fridge, uncovered waste bins, storage of sweeping brushes on the floor, lack of hand washing sinks in laundry areas as well as lack of hand soap in the staff toilet. Kitchens were not clean. Inspectors saw dirty food trolleys and dirty electric sandwich makers and microwaves. There were cobwebs on the ceiling of one kitchen and there was dust between the side of the cupboards and the cooker and between the sides of the cupboards and the dishwasher. These were pointed out to the provider on inspection who stated that external cleaners do not clean the kitchenettes. This is undertaken by night staff. There was no cleaning checklist in the kitchens. In addition, there was dried food evident on microwaves, some microwaves were stained brown internally and some work surfaces were stained. Furthermore, some dining rooms and sitting room floors were dirty and members of the cleaning staff informed inspectors that these were not cleaned on a daily basis, as residents' needs would take precedence. For example, inspectors saw an entry in the cleaning log dated 24 March 2015 which stated "couldn't do dining area today, asked carer X she said no". There was no reason recorded in this log. Inspectors observed that there was a lack of soap dispensers and hand sanitising gel in all houses. Tiles needed grouting in some toilets and in one bathroom the floor covering was separating from the wall creating a risk of dirt lodging in this area, which was not accessible to cleaners. Members of the cleaning staff informed inspectors that they did not fill out details of the cleaning tasks undertaken. They were asked to provide a list of unfinished cleaning tasks instead.

Suitable fire equipment and signage were in place and fire exits were noted to be unobstructed however, inspectors found evidence that all appropriate measures had not been taken in regard to fire safety. For example, some fire doors were kept open with door wedges or chairs and this posed a risk to residents by potentially preventing such fire doors from closing in the event of a fire. Electrical equipment such as fridges and microwaves showed visible signs of ware and tear and microwaves were seen to be apparently smoke damaged on the inside, in some cases. These presented a fire hazard and had not been identified by the health and safety committee as potential fire hazards.

Staff training records as well as staff themselves confirmed that not all staff had been provided with opportunities to attend fire safety training and/or fire drills at suitable intervals for the layout of the centre and the needs of residents. In addition, some staff members informed inspectors that they had never carried out a fire drill in some houses where vulnerable residents were residing. Not all residents had personal fire evacuation plans (PEEPs) in place.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Actions not competed or satisfactorily addressed since the previous inspection were:

-Residents did not have restraint applied in a manner that complied with the centre's policy or with the national guidelines on best practice
-Support plans to support residents who exhibited behaviours that challenged were not up to date or were not always implemented
-Residents were not protected from physical assault from their peers

Two immediate action plans were issued relating to safeguarding as as follows:

1) The provider did not have safeguarding measures in place to ensure that all residents were protected from all forms of abuse in line with Regulation 8 (6)

2)The person in charge failed to notify the chief inspector of an allegation of abuse in line with the requirements of Regulation 31 (1) (f)

The provider submitted a satisfactory response to these action plans within the timeframe set by the Authority.

There was a policy for the protection of vulnerable adults and the Health Service Executive (HSE), 'Trust in Care' document was available in the centre. It was noted during the two days of inspection that staff were familiar with residents and understood the needs and preferences of residents well. Some staff were generally observed communicating with residents in a respectful manner. Staff training records indicated that most staff had been provided with opportunities to attend training in the prevention, detection and response to abuse. However, inspectors formed the view that there were inadequate safeguarding practices for residents as regards allegations of physical abuse. It was noted by inspectors in documentation that unexplained bruises had been noted by a relative between August 2014 and September 2014 and reported to the provider. However, no record of preliminary screening, no investigation or safeguarding plan and no notification to the Authority as required by Regulations in

relation to this allegation had been made. In addition, there was no record of any complaint recorded concerning this bruising and the present person in charge stated that she had no knowledge of the allegation. However, inspectors were informed that senior managers and staff members working with these residents were aware of these allegations.

When reviewing other care plans inspectors noted that a second resident had a record of bruises and marks on his body. However, there was no record of any preliminary screening carried out. In addition, suitable safeguarding practices were not in place in his personal plan. Where the cause of any bruising had been identified there was no plan of care in place to prevent further bruising.

On day two of the inspection an inspector overheard a staff member using an inappropriate tone and raised volume of voice to a resident. The resident was non verbal and had a profound disability. This event was immediately reported to a senior manager who informed the person in charge in the centre. An NF06 was sent to the Authority following the inspection. The Authority received a copy of the safeguarding plan which had been put in place for this resident and appropriate steps were taken to prevent a repeat of this event. Inspectors reviewed incident records which indicated that some residents sustained minor injuries following assaults by some other residents. However, there was no evidence that all required or necessary measures had been taken to prevent these incidents of peer assault being repeated. Some residents therefore were at risk of on-going potential injury from the potentially impulsive and reactive behaviour of other residents. As already addressed in outcome seven, there was not a sufficient number or suitable skill mix of staff employed in the centre to adequately monitor residents and meet all of their needs, which placed residents and staff at risk of injury.

When interviewed by inspectors, the person in charge and the provider acknowledged that suitable training had not been provided for staff. In addition, inspectors noted from staff interviewed that they were not familiar with the procedure for reported incidents of alleged abuse. Staff interviewed informed inspectors that their training involved an explanation of the policy in the centre. Training records viewed by inspectors indicated that ten staff working in the centre did not have up-to-date training on the recognition and response to abuse and in the protection of vulnerable adults. Inspectors noted that seven staff members had yet to receive this training, according to the training records seen. Some of the staff members interviewed during the inspection confirmed that they had yet to receive the aforementioned training.

In regards to the management of behaviours that challenge, inspectors found evidence that, overall, residents had good access to the allied health care team. This was further addressed in outcome 11. Plans of care were in place for residents who exhibited behaviour that challenged and the PCPs identified underlying causes for this behaviour. However, based on a review of training records given to inspectors and from interviews with staff, none of the staff had yet received training in positive behaviour support. Not all staff had up to date knowledge and skills appropriate to their role, to respond to behaviour that was seen as challenging and to support residents to manage their behaviour. This deficit in training was confirmed by the provider.

Staff confirmed that inadequate staffing levels resulted in episodes of escalated behaviours that challenge for individual residents. In addition, the behaviour plans seen by inspectors did not fully address the behaviour witnessed by inspectors and there was no follow up with staff following escalated events. For example, inspectors noted that a resident who had a behaviour plan and 'obsessive compulsion routine' guidelines in place did not always have the guidelines successful implemented. A staff nurse informed inspectors that not all staff followed the behaviour plan. In addition, inspectors observed in the nursing notes that this resident's behaviour had escalated recently. It was evident from the nursing notes that that a staff nurse had alerted a manager to this on 1 March 2015. However, there were no extra resources or strategies provided to support staff in managing this escalated behaviour. Staff informed inspectors that they felt an additional staff member was required in this house, to ensure that all residents' needs were met and to support the resident who was exhibiting these behaviours that challenge.

A further example of this issue was witnessed by inspectors on the second day of inspection. Inspectors observed one resident screaming and running up and down the corridor in a highly agitated state. Inspectors observed that staff members were not available to de-escalate the behaviour. One staff member was assisting a resident in the bathroom, one staff was on tea break and the third member of staff was inside a bedroom. In response to this behaviour inspectors noted that there were no de-escalation techniques employed to calm, distract or support this resident and other residents, who were witnessing this distress. It was noted in personal care plans that other residents in this house also exhibited behaviours which challenge. However, inspectors formed the view that the volume of the verbal outbursts was very distressing for all residents in this house and may have impacted on their behaviour, as the environment was not suitably relaxing or calm.

There was a policy in relation to the use of restrictive procedures, individual residents were assessed if the need for restraint was identified and their need for restraint was referred to a multi disciplinary restrictive practices review committee (RIRC) for consideration. However, inspectors found clear evidence that best practice was not in place in the case of residents requiring physical restraint. Inspectors were informed by a staff nurse that physical restraint was applied by staff when obtaining routine blood tests, cutting nails, cutting hair and brushing their teeth. Inspectors observed a staff member attempting to cut a resident's nails. The staff member called another staff to help her to hold this resident's hand. The staff member did not continue with this attempt when questioned by inspectors as she said too much 'force' would be required. It was not clear from speaking with staff and from the resident's records if residents' right to refuse any such intervention had been respected or recorded or whether any other alternatives had been explored. There were no specific plans of care in place to support staff in providing such interventions or for identifying when such approaches would have been suitable, appropriate or necessary.

Physical restraint:

One resident was restrained with the use of a groin harness. Inspectors were informed by the staff nurse that this resident was physically restrained due to:
• risk of falls

• insufficient numbers of staff
• unsuitable environment
• hitting out at others

Suitable records were not maintained in the centre for the use of the restraint. There was no risk assessment to indicate the frequency at which the restraint should be released and for what period of time. In addition there were no records maintained of any time when the restraint was released. Inspectors noted that the resident appeared to be attempting to get out of the chair as he had removed the attached side-table and he was stretching down touching the floor. Inspectors observed that this resident was indicating distress and discomfort by his facial and verbal expressions. When he was released and allowed on to the floor he was seen to be smiling and appeared much happier. In addition, there was no documentation in this residents' PCP to guide staff on the use of the restraint or any document to indicate that its use had been assessed by the RIRC.

The policy on restrictive interventions stated that the RIRC reviewed all restrictive practices. The documentation from the RIRC in relation to this groin restraint was reviewed in a master file in the office of the person in charge. However, this document was unsigned and undated and referred to the use of the groin restraint "to prevent falling from chair". There was no evidence of review or follow up by the RIRC. This documentation was seen to be a generic form and was not specific or individualised to the needs of the resident. The groin restraint had been deemed by the RIRC, to not be 'a restrictive practice'. However, there was no review of the type of restraint or the suitability of such restraint. In addition, the groin restraint was seen to be stained and smelled of urine. This restrictive practice arrangement was not risk assessed and there was no care plan available to support the resident when such restraint was in use. On both mornings of the inspection the resident was reported by staff members to have been restrained in this chair since 06.50 am.

Chemical restraint:
Records seen by inspectors indicated that another resident was given medication in response to an episode of behaviour that challenged. The record dated 27/09/14 and recorded an episode of disturbed behaviour between 20.40hrs and 23.25hrs which culminated in the administration of IM (intra muscular) sedation. In the protracted period of time during which the behaviour that challenged occurred, a staff member had been assaulted and extra staff had been called to the house to support the staff on duty. It was recorded that, when a staff member noticed that the resident did not have any socks on and she gave these to him, the behaviour was diffused. However, by this time the resident had already been given the IM sedation.

Environmental restraint:
Some residents were observed by inspectors to have bedrails in place. However, the use of bedrails was not risk assessed as to their suitability since 23/07/2014. Inspectors noticed that bedrails could be manipulated, due to their design. For example, they could be readjusted to a higher position by the addition of an extra rail. Inspectors observed that this rail was not fixed in position but could be moved in a side-to-side motion. This posed a risk of entrapment to the resident. This issue had not been identified on the risk assessment. While night staff were noted to be recording checks on the use of this

restraint there was no corresponding checklist in place for day staff. This was required as the resident with the aforementioned addition to his bedrail, spent long periods of time in bed during the day, according to the staff nurse. There was no indication however, that the use of bedrails for both residents in this house had been referred to the RIRC for assessment, as per the centre's policy. Neither resident could get out of bed when the bedrail was in situ. There was no consent form, or risk assessments seen in the personal care plans of those residents who were deemed to require bedrails.

Physical Restraint:
Records for a fourth resident in another house indicated that a particular physical intervention which was designed to be used as 'a last resort' was used on three occasions for a resident. This was a method of forcefully holding and moving a resident involving two staff members. The resident on which this intervention was used was seen by inspectors to be of small stature. There was no care plan to indicate the therapeutic support to be offered following this intervention. There was no risk assessment done by a suitable qualified person as to whether this resident was physically able for the intervention. The previous use of this restraint had been assessed by the RIRC. Documentation from the committee seen by inspectors and dated 13 February 2014 indicated that the RIRC were concerned that the staff member involved in applying this restraint had failed on each occasion to fill in page '4' of the restraint record. This record dealt with the resident's feelings or any distress caused by the intervention, any follow up actions carried out and whether relatives had been informed. The committee had also questioned the suitability of this resident's environment and asked whether his current environment could be adapted. However, these issues had not been addressed and staff confirmed to inspectors that these issues had been discussed in the past. Inspectors also noted that staff had failed to document a comprehensive list of alternative, less restrictive interventions which had been attempted prior to the use of the restrictive 'hold'.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
As required by Regulation, notification of allegations of abuse and the use of restraint had been not been forwarded to the chief inspector:

For example:

Notification of a allegation of abuse had not been made to the Authority concerning a complaint of unexplained bruising.

Notifications of the incidents of the use of restraint had not been made to the Authority as required by Regulation for example :
-one resident was restrained in a chair daily, as observed by inspectors and confirmed by a staff nurse
-two residents had bedrails in use which they were incapable of removing and staff informed inspectors that these residents could not get out of bed because of the bedrails
-inspectors saw evidence in a resident's care plan that chemical restraint had been used for a resident who was exhibiting behaviour that challenged
-inspectors saw evidence in documentation on restraint, that physical restraint had been utilised by two staff members on a resident, on three occasions.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Action not completed or satisfactorily progressed since the previous inspection:
-Appropriate care was not provided to each resident, having regard to their personal plan.

Two immediate action plans issued relating to Healthcare needs were as follows:

1) The person in charge failed to ensure that medical treatment was provided to a resident where the health care professional caring for the resident had deemed such treatment to be "urgent": Regulation 6 (1) (b)

2)The registered provider is failing to provide appropriate health care for a resident having regard to a resident's plan for his medical, social and physical needs.

The provider submitted satisfactory responses to the immediate action plans within the timeframe set by the Authority.

Inspectors found that residents were frequently reviewed by general practitioners (GP) and that they generally had access to allied health professionals, such as, registered

nurses, speech and language therapist, dietician services, psychologists, and occupational therapist. Contrary to findings on the previous inspection inspectors saw that a resident's decision to refuse a routine blood test was respected and documented. Throughout the two day inspection period inspectors observed evidence of some caring and empathic interactions between staff and residents. Staff in some houses were seen to use 'Lamh' skills with residents when assessing their needs. Other staff were seen to prepare the evening meal using fresh vegetables and meat and inspectors observed that there was a plentiful supply of fresh meat, fish, fruit and vegetables in the houses. A number of staff spoken with by inspectors expressed dedication and interest in residents' holistic care. Some staff expressed that they were anxious to be facilitated to take residents out more frequently and to be able to attend to residents on a one to one basis where required. Staff expressed to inspectors that they were aware that the resources had not been made available for this to occur.

On reviewing a sample of residents' personal plans inspectors found that not all residents were supported to achieve and enjoy the best possible health care. For example, not all residents' PCPs were reviewed and updated if a resident's condition changed. Consequently, care plans currently in place did not accurately reflect the status of a resident or did not accurately outline the health care that was required to meet his/her healthcare needs. This was verified when a staff nurse informed inspectors that a resident who had been vomiting over the weekend had not been seen by a doctor on the following Monday morning, as this nurse had requested. This staff nurse informed inspectors that she considered this issue to be a case for 'urgent' review as the resident had a significant medical history. However, when the staff nurse returned to duty on the following Wednesday, during the inspection, this resident had not been seen by a doctor. The staff nurse had previously documented that she had reported this issue of concern to a manager. Records to support this event were seen by inspectors. Inspectors noted that the GP came promptly during the inspection, when requested by staff and reviewed the resident.

Inspectors found individual residents had their health care information kept in several different files, as well as in various locations which did not provide for ease of retrieval of information. It was difficult to extract the current and relevant clinical information due to the incomplete information in some of the PCPs. Inspectors formed a view that this arrangement in relation to the management of residents' health care information posed a risk of poor communication of care issues. In addition, it did not facilitate continuity of care as essential information, relating to residents' health care needs, could be missed or not communicated between healthcare professionals. For example, a staff nurse informed inspectors that staff would verbally hand over information about a particular resident, as regards his behaviour and his daily obsessive routine which had led to miscommunication and poor continuity of care. Inspectors witnessed this verbal handover at the morning handover report on the first day of inspection. The report in relation to this particular resident was recorded by inspectors as 'brief' and inspectors did not get any indication from the details given to the group of staff that this resident's needs were so complex. A further example of the impact of inadequate communication on residents' care was observed when inspectors noted that not all staff members in one house were aware that there was a 'support belt' available for safe handling of a resident with mobility needs.

Inspectors reviewed the personal care plan of another resident with high physical and medical needs. This resident had been assessed on 18 September 2014 as requiring specialist, neurology, gastroscopy and urology referrals. However, inspectors noted that these referrals had not been followed up. In addition, inspectors noted in the residents' personal care that this resident's psychotropic medications had been increased and decreased on numerous occasions in response to changes in behaviour. Staff stated in records viewed, that there was a "severe" deterioration of his condition. Inspectors observed an unsigned, undated note in this resident's file which stated that a conversation had been held with a neurologist which indicated that a neurology review was not warranted. There were other incomplete forms seen in this resident's file as regards the other, aforementioned, referrals. Irrespective of any job description being available for staff, the person in charge and staff nurses had a duty of care to follow up on referrals. However, inspectors noted there was a lack of clarity among staff as to where this responsibility lay. Further unsigned, handwritten nursing notes were seen in the resident's file concerning a multidisciplinary meeting held on 12 September 2014. However, inspectors noted that this resident's behaviour management plan was not adequate as it made no reference to his extreme sexualised behaviour or his incontinence. In addition, there was no correlation between notes from the psychiatrist and the guidelines for staff on managing the behaviour challenges associated with this residents' disability. A staff nurse spoken with by inspectors stated that the referrals were discussed at a case conference on 24 March 2015. However, there were no minutes of this meeting available for review by inspectors or for reference by staff.

Further examples of residents' personal plans and healthcare needs not being updated on a regular basis or when residents' needs changed were as follows:

~A resident's notes reviewed by inspectors referred to an 'epilepsy' plan which was incomplete. A seizure record for this resident was not updated since 2014 even though inspectors noted that he had been transferred to hospital with seizure activity on 28 January 2015. Changes to this resident's medication to control his seizures had not been reflected in his epilepsy management plan.
~In addition, there was no plan in place for a resident's dietary intake even though he had been prescribed for dietary supplements. He had been last reviewed by the dietician on 4 February 2014.
~A staff member identified three residents to inspectors, whom she said required occupational therapy review for specific seating. However, she stated that she was informed that there were 'no funds' for this.
~Furthermore a resident who had been assessed as at 'high risk' of self harm was last assessed on 11 August 2014. A review was due in February 2015 however, this had not taken place.
~One resident was assessed as having a 'choking' risk however, this resident did not have a review of this assessment completed which was dated as due on 8 August 2014.

Based on records seen and from information obtained from staff interviews, inspectors formed the view that there were serious deficits in the care provided to some residents in the centre. Arrangements in place to identify and alleviate the cause of a resident's deteriorating condition and behaviour were inadequate and this had a serious impact on the health and welfare of all residents in the centre. In addition, behaviour plans reviewed were inadequate and did not reflect the concerning behaviours exhibited and

reported by staff. Inspectors were not satisfied that suitable and appropriate arrangements were in place to ensure that the welfare, wellbeing and quality of life of all residents were supported and enhanced.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
The centre had a written medication management policy to guide the administration of medication in the centre. However, practices around medication administration were observed by inspectors to be unsafe. Inspectors formed this view due to the staff nurse rota which meant that one nurse was on duty between two houses. The nurse was responsible for administering the medications in both houses throughout the day. Nurses were seen to be interrupted on several occasions during the medication round in order to attend to staff personal alarm calls from other houses and to attend to residents' needs. The medications were prepared for administration on the kitchen work surfaces which were often cluttered and unclean. Medications were stored in a locked press in the kitchen however, inspectors found laxative and rehydration sachets in an unlocked press in the kitchen. The nurse explained that they were left there for administration by care assistants later in the day, if she was busy. However, according to the centre's policy on medication administration only nurses were authorised to administer medical products to residents in the centre.

In addition:

-the maximum dosage of PRN (as required) medications was not always documented.
-there was inappropriate storage of a tub of pain relieving medication which was labelled as containing 8 tablets but contained 30 tablets.
-a bottle of eye/ear drops which had been dispensed in October 2014, and should have been disposed of one month after opening, was still being administered to a resident, who was prescribed this medication for continuous use.
-care support workers on duty in one house were not trained in the administration of buccal midazolam (emergency medication for seizures) even though a resident in their care was prescribed this medication. Therefore, a nurse would have to be called from another area, which could result in a delay which subsequently may have serious medical implications for the resident involved.

There were large quantities of nutritional supplements stored in a fridge in the kitchen of one house. These items should be stored in a designated fridge. These supplements were administered as prescribed however, there was no evidence in the care plans to indicate a dietician review or recommendations to support the use of these supplements. Three residents were prescribed a supplement which was recommended for the management of chronic wounds which none of these residents had. In addition, one resident who was prescribed three different supplements was noticed also to have a high cholesterol level.

There was no record of medication errors or incidents throughout the course of the inspection. No medication audits were conducted to demonstrate that the system for medication management was being reviewed.

On reviewing a resident's nursing notes an incident involving the use of chemical restraint for a resident, a psychotropic drug was documented as given to control behaviour. This was not notified to the Authority in the quarterly notifications as required by Regulation.

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

Findings:
There was a centre specific statement of purpose available in the centre however, it did not contain all of the information set out in Schedule 1 of the Regulations as it did not include:

• the specific care needs that the centre was intended to meet
• the services which were to be provided by the registered provider to meet those care needs
• the age range and gender of the residents for whom it was intended that accommodation should be provided
• the sizes of the rooms in the centre
• a correct organisational structure
• arrangements made for residents to access education, training and employment.

Judgment:

Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
One immediate action plan issued in relation to governance and management was as follows:

The registered provider is failing to ensure that effective management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to resident's needs consistent and effectively monitored as required under Regulation 23 (1) (c).

The provider submitted a satisfactory response to the action plan within the timeframe set by the Authority.

The person in charge was based full-time in the centre and had been appointed to the post following findings of inadequate governance and management systems at the time of the previous inspection of 5 and 6 Nov 2014. The nominated provider had recently been appointed to his post also, since January 2015. The provider informed inspectors that he visited the centre weekly and was in contact regularly with the person in charge regarding the operational management of the service. However, inspectors found significant and seriously inadequate governance arrangements in the centre. Appropriate management and staff resources had not been put in place to ensure that staff were adequately supervised and supported to ensure that the service provided was safe, appropriate to residents' needs and effectively monitored. This had a significant negative impact on the care for residents as already detailed in outcomes one, five and 11.

The person in charge was supported in her role by two clinical nurse managers. However, inspectors formed the view that communication amongst the management team was poor. An example of this was that the person in charge stated that she had not been made aware of the medical needs of a resident who had been sick over the weekend. The resident had not been seen by a doctor despite this being requested and reported to a clinical nurse manager. In addition, the present person in charge or the

present provider had not been made aware of the complaints in relation to unexplained bruising, already referred to under outcome eight, which had been brought to the notice of the previous provider. The present provider had clearly not been made aware of the lack of healthcare attention and expressed 'shock' at the seriousness of the inspection findings.

Inspectors were informed that no staff member, including the provider, the care staff or care support workers, had received a job description. Therefore this led to potential lack of clarification in relation to staff roles or related responsibilities for all members of staff. For example, a staff nurse with whom inspectors spoke stated that she was not sure who was responsible for following up on specialists' appointments, which in one example were outstanding since 2014, as referred to under outcome 11: Healthcare needs.

Inspectors also found that effective management systems were not in place in regard to reviewing and improving the quality and safety of care. The person in charge confirmed at interview that there was no record of any annual review of quality and safety of care in the centre. In addition, the provider informed inspectors that unannounced six monthly visits to the centre had yet to commence. A review of care plans by inspectors identified gaps in documentation which the six monthly unannounced visit may have highlighted:

For example:
-all risks had not been identified, such as risk associated with the use of restraints
-the healthcare needs of residents were not met in a timely manner and referrals to specialists were not followed up by management
-there was a lack of follow up and review of care plans on behavioural issues which had escalated since the previous review
-requests for increased staff levels were not addressed
-residents were seen to be accommodated in unsuitable, unsupported environments
-restraints were used without safeguards and authorisation.

Inspectors formed the view that the absence of job descriptions and poor communication systems lead to ambiguity and lack of clarity in the responsibility for the delivery of services for residents. This had a resultant negative impact on outcomes for residents and on morale of staff.

Judgment:
Non Compliant - Major

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

Theme:
Use of Resources

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

implemented.

Findings:
There was evidence that adequate resources had not been made available in regard to the provision of a sufficient number and suitable skill mix of staff to ensure the delivery of safe and effective care to all of the residents. This has already been addressed in outcomes one, five, seven and eight, 11 and will be further addressed in Outcome 17.

As already addressed in outcomes six and seven, the centre had not been adequately resourced in regards to ensuring the premises was clean and well maintained. In addition, old, worn appliances and torn furniture were not repaired and replaced where necessary.

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:
Inspectors observed and were informed by staff that there was not a sufficient number and suitable skill mix of staff employed and appropriately deployed to ensure the delivery of safe and effective care to all residents. The nominated provider, the person in charge and staff with whom inspectors spoke confirmed same. The negative impact on residents' welfare of inadequate staffing levels has already been addressed throughout this report.

There were insufficient whole time equivalent staff numbers to meet the requirements of the roster and the staffing shortfall was filled by a relief staff panel. On day one of the inspection, 31 March 2015, at a meeting with the inspector manager at 15.35hrs, the person in charge stated that she required five extra full time staff to meet the needs of residents. This was in addition to the existing 72.5 staff and she stated that she would still require access to the relief panel to cover holidays, sickness and unexpected events. She stated that a minimum of three staff per house was required to bring the centre into compliance with the Regulations in relation to staffing. However, she stated that she did not have access to enough resources to meet this requirement.

Based on observations by inspectors and interviews with staff, inspectors were not satisfied that there were sufficient staff members on duty in each of the houses to meet the physical, psychological and social needs of the residents. This was supported by the fact that one resident spent a significant period of time inappropriately restrained in a chair. In addition, the arrangement of each nurse having to cover for another nurse's duties in a second house only compounded this situation further. Furthermore, residents with severe and profound needs spent long periods of time unattended in undignified conditions, as witnessed by inspectors, primarily due to the lack of staff to support and supervise them on a one to one basis.

As addressed under outcome eight, the policy on restrictive interventions stated that restrictive interventions should not be used to overcome lack of staff supervision. However, staff with whom inspectors spoke said that the resident was restrained due to the unavailability of staff to assist him to walk or to supervise him when crawling on the floor, which was his preferred way of mobilising.

Activities both within the centre and external to the centre were limited due to inadequate staffing. Staff spoken with by inspectors stated that they didn't have enough time to spend with residents due to lack of staff. Staff members indicated that there was a shortage of transport and suitably trained drivers to ensure that residents could be integrated into the community. Staff stated to inspectors that their ability to support residents in implementing their short term goals, as addressed under outcome five, was restricted by the lack of staff and funding. In addition, therapeutic interventions could not always be facilitated by staff in an effort to alleviate residents' symptoms such as, provision of meaningful activities, external outings and the use of de-escalation techniques.

Inspectors observed that staff were not appropriately supervised. For example, a recently recruited staff member, providing direct care to residents, did not have induction training completed. The staff member was only three days in the centre. However this member of staff was observed by inspectors to be providing intimate care for a resident, in taking a resident for a bath, without supervision.

Staff training records were reviewed however, they confirmed that staff were not consistently provided with opportunities to attend ongoing mandatory training such as, fire safety, safeguarding and protection and positive behaviour support. An appropriate training programme was not in place for each staff member that was relevant to their role in the centre and which would ensure that a high standard of care was provided to all residents. Examples of this were, medication management training, de-escalation techniques, complaints training, communication practices and training on restrictive practices. In addition, there were a significant number of residents with behaviour that challenged in the centre. However, training records showed that none of the staff in the centre had training in positive behaviour support. For example, a nurse demonstrated to inspectors how she could not get a resident up from the bathroom floor where he lay for extended periods of time. In addition, a staff member told inspectors that she could not adequately support a resident who had become distressed, while waiting for his bath, when the bathroom was engaged.

Inspectors reviewed a sample of staff records and found evidence of compliance in

regard to maintenance of the records that are required for staff as per schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) and Regulations 2013.
Judgment: Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by COPE Foundation
Centre ID:	OSV-0003698
Date of Inspection:	31 March 2015
Date of response:	09 June 2015

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 centre was not operated in a manner that respected the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.
For example:
One male resident with profound needs was accommodated in a house shared with five

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

other residents one of whom was female.
As a consequence of his disability he exhibited a specific behaviour which was part of his 'obsessional' routine.
Inspectors found that his behaviour was not supported by the provision of a suitable placement, a robust care plan and trained staff.

Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:
•Female resident who shares house with male residents is currently transitioning to an adjacent house which supports other female residents. This transition will be completed by 30/06/2015.
•Privacy screens are now available and are used to ensure privacy and dignity when one resident engages in any behaviour affecting his and others right to privacy and dignity.
•Multi-Element Behavioural Support Plans and assessments are being completed for residents. Each resident will have a multi-element behavioural support plan completed by 30/09/2015.
•Multi-Element Behaviour Training is being provided to staff. All staff will be trained in multi-element behaviour support by 31/07/2015.
•Person Centred Plans are currently being completed. Each resident's person centred plan will be complete by 31/08/2015.
•Organisational Complaints Policy is being presented to staff. Policy will be presented to all staff by 31/07/2015.

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resident meetings were not facilitated in the centre and there was no evidence available to inspectors that residents were consulted. There were a couple of undated survey forms available in the centre which had been seen on the November inspection also.

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

Please state the actions you have taken or are planning to take:
•Monthly Residents forums will be facilitated in the centre and will link with the keyworker programme. Keyworkers will attend forums with residents. Current resident who is advocacy champion and has attended keyworker training will assist in facilitating

resident forums.
•Keyworkers in place to advocate on behalf of residents where required.
•Keyworker/Advocacy training is being provided to staff. All staff will be trained in keyworker/advocacy by 30/06/2015.
•Person Centred Plans are currently being completed and will include input from resident's themselves and/or family. Each resident's person centred plan will be complete by 31/08/2015.

Proposed Timescale: 30/08/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents were facilitated to exercise choice and control in his or her daily life. For example:

One resident was seen by inspectors to be restrained for long periods of time in a chair. An un-dated resident survey which had this resident's name attached, indicated that his preference was not to be restrained.
Staff who spoke with inspectors confirmed that there were not enough staff to supervise him and he was not allowed on the floor without supervision.

Staff informed inspectors that they would like to take residents out more to their preferred activities of choice. For example one male care assistant said that he was a key worker for one resident who would like to go swimming daily. However, this was only available on a weekly basis, due to unavailability of transport and staff.

Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
•Restrictive procedure referred to concerning chair restraint was reviewed and applied in accordance with National policy and evidence based practice.
•An additional 5 staff have been recruited with the fifth staff commencing on 01/06/2015 to complement the current existing staffing levels. These additional staff are responsible for supporting residents in consistent and regular current activity schedules and for introducing new activity experiences in consultation with residents, keyworkers and families.

Proposed Timescale: 09/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Each resident had not been provided with access to advocacy services and information about his or her rights.

Action Required:

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

Please state the actions you have taken or are planning to take:
•Person Centred Plans are currently being completed and will include easy read information about accessing advocacy services. Each resident's person centred plan will be complete by 31/08/2015.
•Keyworkers are now in place to advocate on behalf of residents where required.
•Keyworker/Advocacy training is being provided to staff. All staff will be trained in keyworker/advocacy by 30/06/2015.

Proposed Timescale: 31/08/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Each resident's privacy and dignity was not respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships and intimate and personal care.

Examples of this were:

One resident shouted loudly and repeatedly and appeared in significant distress. This was impacting negatively on other residents in the centre.

A resident who exhibited severe behaviour challenges as described earlier, shared the house with others. Inspectors found that he was not afforded protection or respect for his privacy and dignity. Other residents were negatively impacted by their observance of the behaviour and they were not afforded protection and respect for their privacy and dignity.

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

Please state the actions you have taken or are planning to take:
•Female resident who shares house with male residents is currently transitioning to an adjacent house which supports other female residents. This transition will be completed by 30/06/2015.
•Privacy screens are now available and are used to ensure privacy and dignity when one resident engages in any behaviour affecting his and others right to privacy and dignity.
•Multi-Element Behavioural Support Plans and assessments are being completed for residents. Each resident will have a multi-element behavioural support plan completed by 30/09/2015.
•Multi-Element Behaviour Training is being provided to staff. All staff will be trained in multi-element behaviour support by 31/07/2015.

•Person Centred Plans are currently being completed. Each resident's person centred plan will be complete by 31/08/2015.
•Organisational Personal & Intimate Care Policy is being presented to staff. Policy will be presented to all staff by 31/07/2015

Proposed Timescale: 30/09/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents were afforded opportunities to participate in activities in accordance with their interests, capacities and developmental needs.

Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
•Person Centred Plans are currently being completed. Each resident's person centred plan will be complete by 31/08/2015.
•An additional 5 staff have been recruited with the fifth staff commencing on 01/06/2015 to complement the current existing staffing levels. These additional staff are responsible for supporting residents in consistent and regular current activity schedules and for introducing new activity experiences in consultation with residents, keyworkers and families.

Proposed Timescale: 31/08/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents had been provided with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of each residents' disability and assessed needs, and his or her wishes.

Action Required:
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:
•Person Centred Plans are currently being completed. Each resident's person centred plan will be complete by 31/08/2015.
•An additional 5 staff have been recruited with the fifth staff commencing on 01/06/2015 to complement the current existing staffing levels. These additional staff are responsible for supporting residents in consistent and regular current activity schedules and for introducing new activity experiences in consultation with residents, keyworkers and families.

•Keyworker/Advocacy training is being provided to staff. All staff will be trained in keyworker/advocacy by 30/06/2015.

Proposed Timescale: 31/08/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents were assisted and supported at all times to communicate in accordance with residents' needs and wishes as they lacked appropriate knowledge and training in the specific communication skills of individuals.

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:
•Organisational Communication Policy is being presented to staff. Policy will be presented to all staff by 31/07/2015.
•Staff will have Total Communication Training by the Communications Team 31/08/2015.

Proposed Timescale: 31/08/2015

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents were supported to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
•An additional 5 staff have been recruited with the fifth staff commencing on 01/06/2015 to complement the current existing staffing levels. These additional staff are responsible for supporting residents in consistent and regular current activity schedules and for introducing new activity experiences in consultation with residents, keyworkers and families.
•Visitors Rooms will be identified and suitably equipped in each house to provide access to areas that were separate from their bedrooms to meet their visitors in private by 31/07/2015

Proposed Timescale: 31/07/2015

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, by an appropriate health care professional, of the health, personal and social care needs of each resident was not carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

Please state the actions you have taken or are planning to take:
•A comprehensive assessment of each resident's health, personal, social care and support needs will be carried out by an appropriate healthcare professional.

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements were not in place to meet the assessed needs of each resident;
For example:
Access to swimming, to technology and assistive devices where required.

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

Please state the actions you have taken or are planning to take:
•The assessed needs of each resident following the comprehensive assessment will be set out in the individual's personal plan and will reflect each individual's needs and choices. This will enable each individual to participate in meaningful activities.
•An additional 5 staff have been recruited with the fifth staff commencing on 01/06/2015 to complement the current existing staffing levels. These additional staff are responsible for supporting residents in consistent and regular current activity schedules and for introducing new activity experiences in consultation with residents, keyworkers and families.
•Organisational Communication Policy is being presented to staff. Policy will be presented to all staff by 31/07/2015.
•Staff will have Total Communication Training by the Communications Team 31/08/2015
•Where identified use of technology and assistive devices will be made available to

residents.

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The designated centre was not suitable for the purposes of meeting the assessed needs of all residents.

Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
•Each residence will be reviewed by the provider nominee and person in charge to ensure the design and layout of the centre is suitable for its stated purpose in the statement of purpose and function and to assess the suitability of the accommodation for individual residents.

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents' personal plans were not always reviewed annually or more frequently if there was a change in needs or circumstances.

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

Please state the actions you have taken or are planning to take:
•Person Centred Plans are currently being completed. Each resident's person centred plan will be complete by 31/08/2015 and will be reviewed annually or more frequently if there is a change in needs or circumstances.

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all personal plans had updated multidisciplinary input.

Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

•Person Centred Plans are currently being completed. All personal plans will have updated multidisciplinary input.

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews were not always conducted in a manner that ensured 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.

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:
•Person Centred Plans are currently being completed and include input from resident's themselves and/or family. The person centred plan will detail the individual's needs and choices. Each resident's person centred plan will be complete by 31/08/2015

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training had not been provided to enable staff to support residents when transitioning between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

Action Required:
Under Regulation 25 (3) (b) you are required to: Provide support for residents as they transition between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

Please state the actions you have taken or are planning to take:
•Organisational Admission, Transition and Discharge Policy will be presented to all staff by 31/07/2015.

•Any residents who transition between residential services or leave residential services will be supported through the provision of identified training in the life-skills required for the new living arrangement.

Proposed Timescale: 31/07/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all areas of the premises were kept in good repair externally and internally.

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:
•Provider nominee to meet with Facilities Manager on 10/06/2015. All identified necessary repairs to be completed by 31/07/2015

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All areas of the premises were not clean and suitably decorated.

Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
•Provider nominee to meet with Facilities Manager on 10/06/2015. All identified necessary cleaning, including deep cleaning of kitchens, and decoration to be completed by 31/07/2015
•Cleaning rotas in place.

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all equipment and facilities were regularly repaired or replaced as quickly as possible so as to minimise disruption and inconvenience to residents:
For example:
-a residents transport chair
-kitchen equipment
-residents' recreational equipment such as DVD players.

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

as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
•Provider nominee to meet with Facilities Manager on 10/06/2015. All identified equipment servicing, repairs or replacements to be identified and carried out

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all areas of the premises were equipped, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents:
For example:
Not all toilets, baths and shower areas were fitted with grab-rails where appropriate.

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:
•Provider nominee to meet with Facilities Manager on 10/06/2015. All identified assistive technology aids and appliances required to be put in place by 31/07/2015

Proposed Timescale: 31/07/2015

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 risk management policy did not iinclude hazard identification and assessment of risks throughout the designated centre.
Examples of this were:
-there was no risk assessment in relation to the choking hazard posed by the unrestricted access by residents to plastic aprons and latex gloves which were seen to be accessible to residents in the centre. At least one resident was known to have a tendency to swallow inedible objects.
-a room where chemicals and cleaning products were stored was unlocked.
-there were no grab rails in place in some of the residents' toilets.
-some fire door wedges were in use
-inappropriate storage of uncooked food
-staff shortages to support residents who exhibited behaviours that challenge.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated

centre.

Please state the actions you have taken or are planning to take:
•All residents have personal fire evacuation plans in place.
•Local incident review group to be established by 30/06/2015 to review all incidents and ensure arrangements are in place to frequently analyse and learn from incidents
•Individual risk assessments in relation to choking hazards are currently being completed for relevant residents and will be completed by 30/06/2015.
•Staff informed that all cleaning products and chemical hazards are stored in locked cleaning equipment room and staff to ensure that door remains locked at all times.
•An additional 5 staff have been recruited with the fifth staff commencing on 01/06/2015 to complement the current existing staffing levels. These additional staff are responsible for supporting residents in consistent and regular current activity schedules and for introducing new activity experiences in consultation with residents, keyworkers and families.
•Fire safety training for staff will be completed by 30/06/2015.
•Staff will be trained in Food Safety & Hygiene by 30/09/2015.
•Electrical equipment such as fridges and microwaves showing visible signs of wear and tear have been replaced and all microwaves have been replaced.
•Risk Register redrafted on 15/05/2015 and to be reviewed quarterly (15/08/2015) or sooner if required.

Proposed Timescale: 30/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control the risks identified.

Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
•Local Risk management policy amended.
•Risk Register redrafted on 15/05/2015 to include the measures and actions in place to control the risks identified. To be reviewed quarterly (15/08/2015) or sooner if required.

Proposed Timescale: 15/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control the unexplained absence of a resident.

Action Required:
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management

policy includes the measures and actions in place to control the unexplained absence of a resident.

Please state the actions you have taken or are planning to take:
•Local Risk management policy amended to include the measures and actions in place to control the unexplained absence of a resident.

Proposed Timescale: 15/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control accidental injury to residents, visitors or staff.

Action Required:
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
•Local Risk management policy amended to include the measures and actions in place to control accidental injury to residents, visitors or staff.

Proposed Timescale: 15/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control aggression and violence.

Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
•Local Risk management policy amended to include the measures and actions in place to control aggression and violence.

Proposed Timescale: 15/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place to control self-harm.

Action Required:

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
•Local Risk management policy amended to include the measures and actions in place to control self-harm.

Proposed Timescale: 15/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have robust systems in place in the designated centre for the assessment, management and ongoing review of risk.

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:
•Local Risk management policy amended.
•Risk Register redrafted on 15/05/2015 to include the measures and actions in place to control the risks identified. To be reviewed quarterly (15/08/2015) or sooner if required.
•Local incident review group to be established by 30/06/2015 within the designated centre to review incidents.

Proposed Timescale: 15/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents who may be at risk of a healthcare associated infection were not adequately protected by the procedures for cleaning and infection control which were inconsistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

Please state the actions you have taken or are planning to take:
•HSE Infection Prevention and Control will be presented to all staff by 31/07/2015.
•Additional infection control equipment will be present in the designated centre by 30/06/2015

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective fire safety management systems were not in place in the centre:
For example:
-in some areas fire doors were wedged open
-not all staff had received fire training
-not all residents had personal evacuation plans
-not all staff had been involved in a fire drill process with residents
-worn electrical equipment, such as some microwaves, had not been replaced

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:
•All residents have personal fire evacuation plans in place.
•Individual fire risk assessments in relation to are currently being completed for relevant residents and will be completed by 30/06/2015.
•All worn electrical equipment replaced.
•Staff fire safety training to be completed by 30/06/2015

Proposed Timescale: 30/06/2015

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:
The provider failed to ensure that staff had up to date knowledge and skills, appropriate to their role, to respond to behaviour that was challenging and to support residents to manage their behaviour.

Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
•Multi-Element Behaviour Training is being provided to staff. All staff will be trained in multi-element behaviour support by 31/07/2015.
•Management of Actual & Potential Aggression (MAPA) Training is being provided to staff by the Positive Behaviour Support Team. All staff will be trained in appropriate personnel by 31/07/2015.
•HIQA Guidance on use of restraints and Organisational Restrictive Interventions Policy is being presented to staff. Policy will be presented to all staff by 31/07/2015.

Proposed Timescale: 31/07/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

Please state the actions you have taken or are planning to take:
•Person Centred Plans are currently being completed and to include input from resident's themselves and/or family. Each resident's person centred plan will be complete by 31/08/2015. Where identified any therapeutic interventions are implemented with the informed consent resident or representative and these interventions will be reviewed these as part of the personal planning process.

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that where restrictive procedures including physical, chemical or environmental restraint were used, they were applied in accordance with national policy and evidence based practice.

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:
•HIQA Guidance on use of restraints and Organisational Restrictive Interventions Policy is being presented to staff. Policy will be presented to all staff by 31/07/2015.
•Where restrictive procedures including physical, chemical or environmental restraint are used, they are to be applied in accordance with national policy and evidence based practice.

Proposed Timescale: 31/07/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that every effort to identify and alleviate the cause of residents' behaviour was made; that all alternative measures were considered before a restrictive procedure was used; and that the least restrictive procedure, for the shortest

duration necessary, was used.

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:
•HIQA Guidance on use of restraints and Organisational Restrictive Interventions Policy is being presented to staff. Policy will be presented to all staff by 31/07/2015.
•Where restrictive procedures including physical, chemical or environmental restraint are used, they are to be applied in accordance with national policy and evidence based practice.
•Multi-Element Behavioural Support Plans and assessments are being completed/updated for residents. Each resident will have a multi-element behavioural support plan completed by 30/09/2015.
•Multi-Element Behaviour Training is being provided to staff. All staff will be trained in multi-element behaviour support by 31/07/2015.

Proposed Timescale: 30/09/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not sufficiently protected from all forms of abuse by the poor processes and procedures in recording and reporting any allegations of abuse.

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:
•Keyworker/Advocacy training is being provided to staff. All staff will be trained in keyworker/advocacy by 30/06/2015.
•Safeguarding training is being provided to staff. All staff will be trained in safeguarding by 30/06/2015.

Proposed Timescale: 30/06/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident was the subject of an allegation.

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

Please state the actions you have taken or are planning to take:
•All incidents, allegations and suspicions of abuse to be investigated as per National and Organisational Policies

Proposed Timescale: 09/06/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse

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:
•Safeguarding training is being provided to staff. All staff will be trained in safeguarding by 30/06/2015.

Proposed Timescale: 30/06/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to give notice to the chief inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

Please state the actions you have taken or are planning to take:
•PIC/PPIM to adhere to HIQA guidance on notifications. Any notifications of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident will be made to the Authority as set out in Regulation 31 (1) (f).

Proposed Timescale: 09/06/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to provide a written report to the chief inspector at the end

of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
•The Person in Charge (PIC) will provide a written report to the chief inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Proposed Timescale: 30/06/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate health care had not been provided for each resident, having regard to each resident's personal plan.

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:
•Each resident, as part of the person centred plan process, will have their health needs assessed and met by care provided in the centre
•The individual Person Centred Plan will include health action plans. Each resident's person centred plan will be complete by 31/08/2015.
•Each resident has timely access to allied health care services which will reflect their different care needs. All referrals will be followed up.

Proposed Timescale: 31/08/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medical treatment that was recommended for residents had not been made available. For example:
A resident who had been vomiting had not been seen by a doctor where the professional caring for him had assessed the need as 'urgent'.
A resident who had been assessed on 18 September 2014 as requiring specialist, neurology, gastroscopy and urology referrals had not had these referrals followed up.

Action Required:
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is

recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:
•Each resident, as part of the person centred plan process, will have their health needs assessed and met by care provided in the centre
•The individual Person Centred Plan will include health action plans. Each resident's person centred plan will be complete by 31/08/2015.
•Each resident has timely access to allied health care services which will reflect their different care needs. All referrals will be followed up.
•Where medical treatment is recommended and agreed such treatment is facilitated.

Proposed Timescale: 31/08/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that where required, access to services provided by allied health professionals was not made available on a regular basis.
For example:
A staff member identified three residents to inspectors, whom she said required occupational therapy review, for specific seating. However, she stated that she was informed that there were 'no funds' for this.

Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
•The Person in Charge is ensuring that where required, access to services provided by allied health professionals is made available and will be followed up to ensure timely responses.

Proposed Timescale: 09/06/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Support was not made available to all residents at times of illness in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.
For example:
A resident who had severe behaviour and health issues had not been provided with protection for his privacy and dignity and his physical, emotional and social needs were not met by the development of relevant care plans and sufficient and appropriately trained staff members.

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:
•Each resident receives support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.
•Resident's health care needs are met in line with their Personal Care Plan through timely access to healthcare services and appropriate treatment and therapies.
•The individual Person Centred Plan will include health action plans. Each resident's person centred plan will be complete by 31/08/2015.

Proposed Timescale: 31/08/2015

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:
Appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines were not in place in the centre.
All medicine that was kept in the designated centre was not stored securely.

Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
•Staff will adhere to medication management policy, particularly relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.
•Local medication management review group to be established by 30/06/2015.

Proposed Timescale: 30/06/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines were stored in a secure manner that was segregated from other medical products, and were disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.
This referred to a stock of paracetamol tablets and out of date eye drops, still in use.

Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
•Staff will adhere to medication management policy, particularly relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.
•Local medication management review group to be established by 30/06/2015.

Proposed Timescale: 30/06/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not contain the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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:
•Statement of purpose to be updated to contain all of the information set out in Schedule 1 of the Regulations by 30/06/2015

Proposed Timescale: 30/06/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The lack of role and job descriptions meant that there was no clearly defined management structure in the designated centre that identified the lines of authority and accountability, specified roles, and detailed responsibilities for all areas of service provision.

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:
•Management structure outlined and on display in all locations.
•Role Descriptions are being developed for staff. Role descriptions for all staff will be complete by 30/06/2015

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place in the designated centre failed to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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:
•Provider nominee is carrying out unannounced visits of designated centre since 10/04/2015.
•Staff supervision logs are being maintained.
•Annual review of the quality and safety of care and support in the designated centre, in accordance with standards has been carried out (15/05/2015).

Proposed Timescale: 15/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The legislative requirement that there should be 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 was not met.

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:
•Annual review of the quality and safety of care and support in the designated centre, in accordance with standards, has been carried out 15/05/2015.

Proposed Timescale: 15/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider or delegated person had failed 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. In addition, the provider had failed to 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.

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:
•Annual review of the quality and safety of care and support in the designated centre, in accordance with standards, has been carried out (15/05/2015).
•Ongoing unannounced visits by provider nominee have been occurring since 10/04/2015, with support plans developed from these.

Proposed Timescale: 15/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed 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 were delivering.

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:
•Performance Management is to be carried out with each staff member. Each staff member will have performance management carried out by 31/07/2015

Proposed Timescale: 31/07/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the designated centre is resourced to ensure the

effective delivery of care and support in accordance with the statement of purpose.

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

Please state the actions you have taken or are planning to take:
•An additional 5 staff have been recruited with the fifth staff commencing on 01/06/2015 to complement the current existing staffing levels. These additional staff are responsible for supporting residents in consistent and regular current activity schedules and for introducing new activity experiences in consultation with residents, keyworkers and families.
•Clinical Nurse Specialist in Behaviour Therapy based on-site from 05/05/2015 to provide additional support.
•Statement of purpose to be updated to contain all of the information set out in Schedule 1 of the Regulations by 30/06/2015

Proposed Timescale: 30/06/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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:
•An additional 5 staff have been recruited with the fifth staff commencing on 01/06/2015 to complement the current existing staffing levels. These additional staff are responsible for supporting residents in consistent and regular current activity schedules and for introducing new activity experiences in consultation with residents, keyworkers and families.
•Clinical Nurse Specialist in Behaviour Therapy based on-site from 05/05/2015 to provide additional support.

Proposed Timescale: 01/06/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have access to appropriate training, including refresher training, as part of

a continuous professional development programme.

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 have access to appropriate training including all policies and procedures as well as refresher training, as part of a continuous professional development programme

Proposed Timescale: 09/06/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff in the centre were not appropriately supervised

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:
•Management structure outlined and on display in all locations.
•Role Descriptions are being developed for staff. Role descriptions for all staff will be complete by 30/06/2015
•PPIM role to provide more supervision of staff
•Team leaders have been appointed and will be in place by 30/06/2015
•Local Safety Steering Committee will be established by 30/06/2015 to meet and monitor all incidents and accidents and put in safeguarding measures for same.

Proposed Timescale: 30/06/2015