

eDeposit Ireland

A designated centre for people with disabilities operated by Health Service Executive, Westmeath

Item Type	report
Authors	Wynne, PJ
Citation	PJ Wynne, 'A designated centre for people with disabilities operated by Health Service Executive, Westmeath', [report], Health Information and Quality Authority, Compliance monitoring inspection report (Ireland. Health Information and Quality Authority. Regulation Directorate). Designated centres under Health Act 2007, as amended., 2015-07
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-03-13 05:34:58
Link to Item	https://hdl.handle.net/20.500.14765/74355

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003761
Centre county:	Westmeath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Maura Morgan
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
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:
29 April 2015 10:00	29 April 2015 17:30
05 May 2015 09:00	05 May 2015 17:00
06 May 2015 09:00	06 May 2015 13:30

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

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

Summary of findings from this inspection

The centre accommodates nine residents of mixed gender in two separate houses. The specific care and support needs of the residents varied from moderate to severe intellectual disabilities. The service was registered by the Authority as a designated centre prior to residents moving in. The location, design and layout of the two houses of the designated centre are suitable for its stated purpose. All residents have recently moved into their new accommodation. This was the first monitoring inspection of the service since residents transferred to the centre. The inspector met with all residents and reviewed a selection of their person centred plans, support plans and medical files.

Good practice was found in the management of resident’s healthcare. Staff were knowledgeable and responsive to the residents' physical care needs. There was

evidence of referrals for medical investigations and treatment. There was timely access to general practitioner (GP) service. There were regular reviews of psychotropic medication. Residents had access to transport. There are two vehicles provided one for each house to meet resident's transport needs.

A total of 14 Outcomes were inspected. The inspector judged three Outcomes as major non compliant. These included Governance and Management, Workforce and Health and Safety and Risk Management. A further seven Outcomes were judged as moderately non compliant with the Regulations. The remaining four Outcomes were judged as compliant or substantially in compliance with the Regulations.

The areas of major non compliance primarily related to the findings that there was not sufficient protected time available to the person in charge to oversee the governance, operational management and administration of the centre. That there was no contingency plan developed to manage the shortfall in staff. The excessive use of agency staff workers did not ensure residents receive continuity of care and support. The systems and procedures in place to promote the health and safety of residents, staff and visitors were inadequate.

The Action Plan at the end of the report identifies all areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities

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

Outcome 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):

No actions were required from the previous inspection.

Findings:

The person in charge was knowledgeable about the residents needs. It was evident that the residents were familiar with and engaged well with the person in charge. Their documented profiles described well their level of independence and what they could do for themselves. Assessments were completed in relation to independent living, self help skills and nutritional needs.

All residents had single bedrooms. Bedrooms were well personalized with photos and mementos. There was evidence that staff actions maintained resident's dignity and respect when carrying out personal care, with doors closed. There were locks on all bedroom and bathroom doors to ensure privacy. One resident locked his bedroom each day when going to his day service. There was a policy in place that covered resident's personal possessions.

There was adequate storage in each bedroom for clothing and possessions. The inspector reviewed the systems in place to support service users with management of their finances. The safekeeping of resident's financial records did not fully assure their privacy. Financial statements for residents were filed in their medical records and available to all care staff and visiting allied health professionals. An allowance was provided to each house on a weekly basis for grocery shopping and general miscellaneous items. Receipts were retained for all items purchased. The records for the management of the household budget demonstrated clear accounting systems.

Staff were nominated as an agent for residents' pensions. Money was lodged to an account in each resident's own name. Residents' spending money for each week was

held in safe keeping by staff and accessible to residents as requested. A record of the handling of money was maintained for each transaction. Receipts were retained for all items purchased. However, there were no audit arrangements in place by the person in charge to ensure accuracy and transparency in the managing of residents' personal finances. No routine checks were undertaken to reconcile expenses incurred with financial records maintained.

There was a complaints policy in place which is based on the 'HSE- Your Service Your Say'. An easy-to-read version for residents was provided. However, there was not a local complaints policy in place to meet all the requirements of the regulations. A designated person was not named to whom complaints could be made at a local level in the centre. A second person was not nominated in the centre to ensure complaints are responded to and records maintained within the timeframes outlined. The complaints policy included an appeals process based on the 'HSE- Your Service Your Say'. If the complaint was not resolved within the centre, the complainant could bring their complaint to the HSE complaints officer.

The complaint procedure was not displayed prominently in the centre as required by the Regulations. It was in booklet form and left on a side table and not displayed clearly on the wall. The policy stated an appeal could be made to the provider. However, the contact details were not detailed in the policy on the table in one house visited.

Judgment:

Substantially Compliant

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

The individual communication requirements of residents were outlined in their personal support plans. However, there was variation in the level of detail they contained. The communication profiles for some residents described well their preferred routine in all activities of daily living, from getting up, dressed and having their meals and what they could do for themselves. A communication strategy was developed for one resident in conjunction with the speech and language therapist. This included pictorial communication aids. Each resident had a hospital passport completed to outline all their required information in the event of a transfer to an acute hospital.

However, all non verbal residents' communication profiles were not developed to a high standard. Each resident with a difficulty expressing themselves did not have a

communication plan in place. There is a reliance on agency staff and some staff did not know the residents well on the days of inspection. In the absence of well developed communication plans it was difficult for some staff to understand resident's preferences and the meaning behind their non verbal communication as observed by the inspector.

Judgment:

Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Each resident did not have an agreed written contract detailing the services to be provided for residents and the fees to be charged.

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):

No actions were required from the previous inspection.

Findings:

The inspector met with all residents and reviewed a selection of their personal plans. Resident's files contained information that outlined their health, intimate and personal care needs along with their family contacts and relationships. Risk assessments were

completed to inform care planning and detailed interventions in relation to identified needs. These included behavioural challenges, supports and medical issues.

Residents in the first house visited had personal goals for 2014 identified. The majority of which had been achieved. There was evidence of promotion of individualised goal setting for residents taking account of their preferences, to support and enhance their life experiences. The objectives of the goals in the personal plans for 2014 were both aspirational and idealistic. All residents had moved to a new home. Other goals identified for residents included holidays, concerts and a pilgrimage. There was good use of photos to assist and aid understanding in personal plans. However, no new goals were identified for any residents for 2015.

There was variation in the use of different templates to document personal goals for residents in the past year. Some of the templates did not name staff members to take forward objectives in the personal plan within agreed time-scales. Other templates used did not allow for the recording of the supports required to achieve goals or the reason why goals were not achieved.

The variation in templates used to record personal goals and the content of the personal plans indicated that further monitoring of practice is needed. This is required to fully ensure staff are supported to implement social as well as health care plans for residents, suitable to the complexity of the resident needs. There was limited evidence of appropriate multidisciplinary involvement in resident's personal plans.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The centre accommodates nine residents in two separate houses. The location, design and layout of the houses of the designated centre are suitable for its stated purpose. The houses meet the residents' individual and collective needs in a comfortable and homely way. All residents have recently moved into the houses which were registered by the Authority as a designated centre prior to their transfer.

The houses are well maintained both internally and externally and decorated to high

standard. The communal areas included spacious dining and sitting rooms in each house. Comfortable furniture and fittings are provided. The kitchens were large with ample space for cooking facilities and food storage.

Each resident has their own bedroom. All bedrooms are spacious and doors can be locked from within by occupants to protect their privacy. All bedroom accommodation is provided on the ground floor. The temperature of the hot water in ensembles and bathrooms is regulated by thermostats. Hand testing indicated it did not pose a safety risk to residents.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The systems and procedures in place to promote the health and safety of residents, staff and visitors require review. There are corporate HSE policies in relation to health and safety, risk assessment and incident reporting. However, there was not a centre specific health and safety statement developed for the centre. An evidence-based risk assessment tool was available for use. A risk register was maintained and actions were identified to minimise any hazards.

However, a documented risk assessment of the premises was not undertaken to identify any potential hazards since it was newly occupied by the residents. In one bathroom the overhead tracking hoist was not accessible to the bath as it was obstructed by a support rail in the shower area. Access or egress from external garden in the second house visited was not ensured. One gate was secured with a keypad while the other gate was open-able. The fire exit door was not alarmed if opened by a resident providing access to the rear garden and unsecured gate.

There was a missing person policy in place and this provided good detail on the procedure to follow should a resident leave the centre unknown to the person in charge. Photographic identification was available for all residents and profile description sheets were completed. An emergency plan was developed. However, the specific contact details were not completed and all emergency arrangements defined. The risk management policy did not include documented procedures to guide staff responses to events such as aggression, violence and self harm.

Due to the dependency of residents hoists were required by staff to assist with moving

and handling two residents in a safe manner. A moving and handling assessment was completed. There was evidence of good input from the physiotherapist in the moving and handling assessment completed in one file reviewed. However, three staff were identified as requiring refresher training in safe moving and handling as their current certificate of training had expired.

There were some residents with a diagnosis of epilepsy. Each resident had a detailed plan to guide staff actions and intervention to ensure the resident's safety. The centre is staffed by a single care assistant some nights each week. Care staff are not trained in the administration of emergency medication in the event of a continuous seizure by a resident. While the policy stated the emergency services are to be contacted this intervention may not manage the situation in a timely manner in the best interest of the resident's safety.

Fire safety equipment including the fire alarm, fire fighting equipment, emergency lighting and smoke detectors were provided and were serviced quarterly and annually as required. Fire notices describing the action to take on discovering a fire were located beside the fire panel. Regular fire safety checks were completed to ensure exits were unobstructed, fire extinguishers were in place and intact and automatic door closers were operational.

All residents had a personal emergency evacuation plan in place. In the first house visited fire drills were undertaken. However, all staff did not participate in routine fire drills to reinforce their theoretical knowledge from annual fire training. The fire drills require further development to ensure the records maintained detail the scenario/type of simulated practice, the time taken for staff to respond to the alarm and to evacuate. There was limited evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required. None of the personal emergency evacuation plans were revised following a fire drill practice.

All regular staff had completed fire safety training. Agency staff were inducted in the fire safety protocols on commencement of work at the centre. No agency staff were rostered for night duty. However, due to the high reliance of different agency staff the precautions to ensure residents safety in the event of fire were not risk assessed. Agency staff did not have the opportunity to participate in regular fire drill practices and were unfamiliar to residents. In the second house visited on the first day of the inspection three of the complement of four staff were from an agency. On the second day of inspection two of the staff were from an agency.

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):

No actions were required from the previous inspection.

Findings:

No notifiable adult protection incidents which are a statutory reporting requirement to the Authority have occurred or being reported to date. Staff to whom inspectors spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. However, all staff did not have refresher training in the protection of vulnerable adults. Intimate care plans were in place for all service users. Nursing staff are assigned as key workers with responsibility to complete a number of plans each.

Staff were trained in the Management of Actual or Potential Aggression (MAPA). However, training in the management of behaviour that is challenging was not fully complied with for all staff. The model of behaviour management utilised by the centre was not clearly defined in policy. There was not a positive behaviour support policy developed and in place to guide staff on this principle of behaviour management. There was a documented strategy for 'support of individuals with behaviours of concern'. However, the procedures only guided staff on making referrals to psychiatry, completing the incident analysis forms and completing a daily log of behaviours.

There was good evidence of regular reviews of psychotropic medication to ensure optimum therapeutic values by the psychiatry team. The majority of residents with behaviours that challenge had a behaviour support plan. However, the inspector identified one resident in the second house visited with behaviours that challenge during personal care and some self injurious behaviour. A behavioural support plan was not developed to guide staff in their interventions. Residents did not have access to a psychology service. There was no evidence of input or review by a psychologist into care plans for residents developed by the behavioural support therapist. There was no psychology input to the multi disciplinary involvement in responding to behaviours that challenge.

On occasion there was evidence of some restraint management practices. These were either pharmacological or mechanical and in response to escalation in a resident's behaviour which posed a risk to the resident's own safety. In three care files examined, one in relation to physical restraint and two in relation to chemical restraint there was evidence of good practice in planning and responding to situations. A restrictive intervention assessment is undertaken and supported with a plan of care. A review is completed post the emergency use of a restrictive intervention. However, in the absence of a defined policy there was variation in the standard of restraint assessment and post incident review.

There was not a policy on the use of restrictive procedures developed and in place to

guide staff. There were no procedures on restraint management detailed in the strategy 'support of individuals with behaviours of concern'. This is discussed further under Outcome 18, Records and Documentation.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

In the majority of instances there is opportunity to participate in activities and outings. Most residents in the first house visited had access to a day program/service of a frequency and duration suitable to their level of ability and age. However, two residents who did not have a day service. Options were being explored in one case. However, the meetings had not concluded with the provision of a suitable day program for the resident. No option had been explored for the resident in the second house visited.

The opportunity for adequate sensory stimulation, participation and support to maximise quality of life for some of the residents in the second house visited was impacted upon by the limited availability of staff and the need for one to one care for a resident. Service user had access to transport. There are two vehicles provided one for each house to meet resident's transport needs.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

Findings:

Nursing staff were knowledgeable and responsive to the healthcare needs of residents. There was evidence of referrals for medical investigations and treatment. There was timely access to (GP) service, including out-of-hours.

Residents had access to optical, speech and language, occupational therapy, psychiatry, dental and chiropody services. There was evidence nursing care plans were updated to reflect changes and recommendation from allied health professionals. However, as identified previously in the report residents did not have access to a psychology service. The inspector noted two residents in the second house visited had not been referred or reviewed by the physiotherapist. The management team concluded in conversation with the inspector the residents would benefit from a passive exercise or physical activity program. Risk assessments completed identified their mobility as poor.

There was evidence residents had been referred to a dietician and their recommendations were updated into care plans. Residents with swallowing difficulty were reviewed by the speech and language therapist. Staff were familiar with the different types of modified diets required by residents and could describe well to the inspector how their individual dietary needs are met.

There was a nutritional policy in place. There were two residents with a percutaneous endoscopic gastrostomy (PEG) feeding system in place. Residents' privacy was ensured at meal times. All residents were weighed monthly and at the time of this inspection there was one resident being weighed weekly. However, there was not an evidence-based nutritional risk assessment screening tool available for use. Staff to whom inspectors spoke stated that the quality and choice of food was frequently discussed with individual residents and changes were made to the menu accordingly. The inspectors noted the fridges were well stocked with a variety of nutritious and wholesome food. Residents' went out for meals and ordered in takeaways at intervals during the week.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

While there was a medication management policy in place to guide practice it was not specific to the centre. The policy was generic to cover all types of HSE services within the administrative region. Staff were knowledgeable on the different medications and their functions. The inspector reviewed a sample of drugs charts. An assessment was

not undertaken to ascertain if a resident had the capacity to manage their own medication safely. A risk assessment tool to guide staff in their decision making to facilitate residents who may wish to self medicate was not available.

All medication was dispensed from individual packs each with the resident's own name. The inspector noted some bottles of PRN liquid medication were not dated as to when they were initially opened. The inspector reviewed a sample of drugs charts. All prescribed medication was individually signed by the GP (general practitioner). The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

A written statement of purpose was available. The statement of purpose submitted required review to ensure more clarity in certain aspects. The areas requiring review include;

The Statement of Purpose did not contain the information set out in the certificate of registration.

A description of the sizes of all the rooms in the designated centre was provided in the form of a floor plan. However, due to the scale of the drawing the sizes were not legible. Due to a change in management the person nominated to deputise in the absence of the person in charge was inaccurate. The arrangements to attend religious services of choice were generic and the number of residents, their sex and age range accommodated in each house was not detailed.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

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

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

Findings:

The person in charge worked full-time and is suitably qualified, skilled and experienced to manage the centre. During the inspection the person in charge demonstrated good knowledge of the legislation and of her statutory responsibilities. Records confirmed that she was committed to her own professional development. The person in charge had good knowledge of residents care needs and could describe in an informed way where residents had specific needs. She described how staff were working to develop care pathways to ensure residents social and health care needs were met appropriately since moving into their new accommodation.

However, there was not sufficient protected time available to the person in charge to oversee the governance, operational management and administration of the centre on a consistent basis. While there was hours allocated to governance on the roster the person in charge was primarily involved in residents care. The person in charge covers work shifts for holidays and sick leave.

The system to review the quality and safety of care and quality of life requires further development to ensure a more robust approach in line with the requirements of Regulation 23. While the person in charge has completed some audits no reviews have been undertaken in the house accommodating four residents. The person in charge does not have the opportunity to regularly visit this house and review the quality and safety of care, supervise staff and actively oversee the operational management.

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):

No actions were required from the previous inspection.

Findings:

The inspector examined staff rosters, reviewed residents physical care and psychosocial needs in care files. The inspectors met with all residents and discussed with staff their roles, responsibilities and working arrangements.

The inspector found there was not adequate number of care assistants to support the nursing team and to meet the individual and collective needs of residents. An essential baseline for the safe delivery of services indicated four care staff until 17:00 hrs in the house where four residents lived. A review of the worked rosters indicated for one week in April only two care staff were available. In a further two week period there were four days in which only two care staff were available during the month of April. Two of the residents in this house require a high level of support and one to one care.

In the house accommodating five residents the staff level decreased to two from either 16:00 hrs or 17:00 hrs each evening. The staff resources were insufficient from this time to adequately meet the residents' individual needs. Considering the level of support required by residents for evening meals and routine personal evening care, there were limited options for social engagement or sensory stimulation in the evening time.

As described previously in Outcome 2, Communication and Outcome 7, Risk Management there was a high reliance on different agency staff. There was no contingency plan developed to manage the shortfall in staff and the excessive use of agency staff workers to ensure residents receive continuity of care and support. Care plans reviewed for three residents in one house with behaviours that challenge identified the need for familiar staff. One care plan stated 'regular staff familiar to the resident to work alongside on an individual basis only'. The resident had a tendency to engage in behaviours that did not protect her privacy and dignity. A review of the accident/incident register confirmed in one incident report an escalation in behaviours that challenge by a resident due to unfamiliar staff on duty.

The inspector reviewed a selection of staff files and noted that the files did not contain all documents as required under schedule 2 of the regulations. Garda Siochana vetting was applied for all staff members. However, this was not available in the sample of staff files examined.

Records evidenced staff development training was ongoing. Staff had undertaken courses in basic life support and infection control. Mandatory training requirements detailed under Outcomes Seven and Eight including manual handling, protection of vulnerable adults and management of behaviour that is challenging was not fully complied with for all staff. Care staff are not trained in the administration of emergency medication in the event of a continuous seizure by a resident.

Judgment:

Non Compliant – Major

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

A directory of residents was not maintained containing all of the matters required by the Regulations.

Not all of the written policies and procedures as required by Schedule 5 of the Regulations were in place. The policy on behavioural support requires review. The policy did not reflect the model of behaviour management in which staff are trained. The policy did not guide staff in the event of a change or escalation of behaviours to ensure medical investigations are requested to eliminate an underlying physical health problem. As described under Outcome 11, Healthcare Needs, there was not an evidence-based nutritional risk assessment screening tool available for use.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority
Regulation Directorate**

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003761
Date of Inspection:	29 April 2015
Date of response:	26 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:

There were no audit arrangements in place by the person in charge to ensure accuracy and transparency in the managing of residents' personal finances. No routine checks were undertaken to reconcile expenses incurred with financial records maintained.

Action Required:

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

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:

An audit was carried out by the financial manager on May 26th 2015 and we adhere to our service policy. Residents accounts are checked at end of day and reconciled with records and double signature. We are developing a local audit tool for the pic to audit the designate centre on a fortnightly basis

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

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

A designated person was not named to whom complaints could be made at a local level in the centre.

Action Required:

Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

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

The complaints guidance document has been revised and the compliments document developed. This document identifies a number of people an individual can complain to within the designated centre.

The PIC is the person to whom all complaints are made. These will be reviewed at the monthly staff meetings. A picture of the complaints Officer is evident in each designated centre.

Proposed Timescale: 01/06/2015

Theme: Individualised Supports and Care

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

A second person was not nominated in the centre to ensure complaints are responded to and records maintained within the timeframes outlined.

Action Required:

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

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

The PIC has identified a second person to whom complaints can be made. A picture is displayed in the designated centre.

Proposed Timescale: 01/06/2015

Theme: Individualised Supports and Care

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

The complaint procedure was not displayed prominently.

Action Required:

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

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

The complaints, compliments document has been displayed in a prominent place in the front hall.

Proposed Timescale: 01/06/2015

Theme: Individualised Supports and Care

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

The policy stated an appeal could be made to the provider. However, the contact details were not detailed in the policy on the table in one house visited.

Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

The contact details of the provider are now available in the designated centre

Proposed Timescale: 01/06/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

All non verbal residents' communication profiles were not developed to a high standard. Each resident with a difficulty expressing themselves did not have a communication plan in place.

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:

All residents have an up to date communication plan

Proposed Timescale: 04/06/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Each resident did not have an agreed written contract detailing the services to be provided for residents and the fees to be charged.

Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

A contract of care has been developed for each resident in the designated centre which outlines fees and services.

Proposed Timescale: 17/06/2015

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:

No new goals were identified for any residents for 2015.

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:

New goals for 2015 have been set for all residents in the designated centre

Proposed Timescale: 03/06/2015

Theme: Effective Services

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

There was variation in the use of different templates to document personal goals for

residents in the past year. Some of the templates did not name staff members to take forward objectives in the personal plan within agreed time-scales. Other templates used did not allow for the recording of the supports required to achieve goals or the reason why goals were not achieved.

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:

A standard template has been developed within the designated centre to incorporate= staff names, timeframes, supports required to achieve the goals and the reason why goals were not achieved.

Proposed Timescale: 03/06/2015

Theme: Effective Services

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

There was limited evidence of appropriate multidisciplinary involvement in resident's personal plans.

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:

Each individual's needs will be reviewed by the MDT where appropriate and recommendations from the Allied health professionals reflected in the personal care plans .

Proposed Timescale: 22/07/2015

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:

There was not a centre specific health and safety statement developed for the centre.

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:

A Health and Safety Statement specific to the designated centre will be developed

Proposed Timescale: 30/08/2015

Theme: Effective Services

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

A documented risk assessment of the premises was not undertaken to identify any potential hazards since it was newly occupied by the residents.

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:

An assessment of the house and surrounding areas is scheduled to take place in the next 2 weeks by Maintenance Supervisor with PIC and risk assessments will be reviewed accordingly and controls identified to maintain safety.

Proposed Timescale: 15/07/2015

Theme: Effective Services

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

An emergency plan was developed. However, the specific contact details were not completed and all emergency arrangements defined.

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:

A review of emergency plan will take place and all emergency arrangements clarified and contact details will be updated

Proposed Timescale: 30/06/2015

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 documented procedures to guide staff responses to events such as 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:

The Risk Management Policy will be reviewed to incorporate measures and actions to guide staff in relation to control of aggression and violence.

Proposed Timescale: 25/09/2015

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 documented procedures to guide staff responses to 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:

Management Policy will be reviewed to incorporate measures and actions in place to control self harm

Proposed Timescale: 25/09/2015

Theme: Effective Services

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

There was limited evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required. None of the personal emergency evacuation plans were revised following a fire drill practice. All staff did not participate in routine fire drills to reinforce their theoretical knowledge from annual fire training. Agency staff did not have the opportunity to participate in fire drill practices.

Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

1. A plan has been put in place to ensure all staff including agency staff are given the opportunity to participate in fire drills on a monthly basis.
2. All learning from each fire drill will be reviewed at the monthly staff meeting.
3. The outcome of these drills will be documented and changes made to the individual evacuation plans as required.

Proposed Timescale:
1. Complete 8th June 2015
2. 25th June 2015
3. 25th June 2015 Ongoing

Proposed Timescale: 25/06/2015

Theme: Effective Services

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

Due to the high reliance of different agency staff the precautions to ensure residents safety in the event of fire were not risk assessed.

Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

The induction guidelines will be revised to ensure that there is robust guidance in place for inducting agency staff in relation to evacuation procedures of each individual in relation to fire. All agency staff will be involved in monthly fire evacuation drills

Proposed Timescale: 25/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

One resident in the second house visited had behaviours that challenge during personal care and some self injurious behaviour. A behavioural support plan was not developed to guide staff in their interventions.

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:

A review of the individual who presents with behaviours of concern will be undertaken by a behavioural support team. Systems and structures will be developed to guide all staff in carrying out the interventions. All staff will receive training in Positive Behavioural Support

Proposed Timescale: 15/07/2015

Theme: Safe Services

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

There was not a policy on the use of restrictive procedures developed and in place to guide staff. In the absence of a defined policy there was variation in the standard of restraint assessment and post incident review.

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:

The current policy on restrictive practices will be reviewed to ensure that it provides guidance to staff.

Proposed Timescale: 30/08/2015

Theme: Safe Services

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

Training in the management of behaviour that is challenging was not fully complied with for all staff.

Action Required:

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

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

1. All staff will receive training in Positive Behavioural support
2. All staff will receive training in MAPA.

Proposed Timescale: 05/08/2015

Theme: Safe Services

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

All staff did not have refresher training in the protection of vulnerable adults.

Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

All staff will have refresher training in the protection of vulnerable adults.

Proposed Timescale: 31/07/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Two residents did not have a day service. Options were being explored in one case. However, the meetings had not concluded with the provision of a suitable day program for the resident. No option had been explored for the resident in the second house visited.

Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

1. Plans are at an advanced stage to secure a fulltime day service.
2. A specific daily schedule and programme is designed for resident No. 2 which meets their needs

Proposed Timescale: 15/07/2015

Theme: Health and Development

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

The opportunity for adequate sensory stimulation, participation and support to maximise quality of life for some of the residents in the second house visited was impacted upon by the limited availability of staff

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:

Staff are currently in place to provide adequate sensory stimulation, participation and support.

Proposed Timescale: 03/06/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Two residents in the second house visited had not been referred or reviewed by the physiotherapist. The management team concluded in conversation with the inspector the residents would benefit from a passive exercise or physical activity program. Risk assessments completed identified their mobility as poor.

Residents did not have access to a psychology service.

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:

A referral has been made to the physiotherapist and reviews have taken place. The recommendations have been included in the plan of care of each service user and the interventions are ongoing.

Referrals have been made to the Psychology service.

Proposed Timescale: 18/06/2015

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:

The medication management policy in place was not specific to the centre.

Some bottles of PRN liquid medication were not dated as to when they were initially opened.

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:

1. A SOP is currently being developed in medication management in the designated centre
2. All PRN medication will be dated when opened.

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:

An assessment was not undertaken to ascertain if a resident had the capacity to

manage their own medication safely.

Action Required:

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

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

All residents in the designated centre will be assessed for the self administration of medication.

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 submitted required review to ensure more clarity in certain aspects. It did not contain the information set out in the certificate of registration. A description of the sizes of all the rooms in the designated centre was provided in the form of a floor plan. However, due to the scale of the drawing the sizes were not legible.

Due to a change in management the person nominated to deputise in the absence of the person in charge was inaccurate. The arrangements to attend religious services of choice were generic and the number of residents, their sex and age range accommodated in each house was not detailed.

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:

The statement of purpose for the designated Centre will be revised to reflect the requirements outlined in schedule 1 of the regulations. This will include detail description of the rooms including size. The statement of purpose will also reflect the change in management in the centre and the specific details relating to the service users.

The arrangements to attend religious services of choice will be specified in the statement of purpose and the number of residents, their sex and age range accommodated in each house will also be detailed.

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:

There was not sufficient protected time available to the person in charge to oversee the governance, operational management and administration of the centre on a consistent basis.

Action Required:

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

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

The PIC has 16 hrs protected time per week to manage the designated centre.

A Nurse on 6 month Agency Contract has been recruited to commence working 16 hours per week in the designated centre.

Business cases have been submitted and is currently at the National Recruitment stage to recruit Nurses in the designated centre

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 system to review the quality and safety of care and quality of life requires further development to ensure a more robust approach in line with the requirements of Regulation 23.

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:

The date for the quality and safety annual review has been set to include the views of the families and the residents.

Proposed Timescale: 18/06/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

the following respect:

There was not adequate number of care assistants to support the nursing team and to meet the individual and collective needs of residents.

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:

Adequate number of care assistants are in place to meet the assessed needs of the residents. Complete

4 Health Care Assistants from Agency have been allocated regular lines on the Roster. Complete

6 Month Agency Contracts will be offered to all Agency Health Care Assistants in the designated centre.

Business Cases are in the process of been submitted to recruit 4 Health Care Assistants at National Level. 1st October 2015

In the house accommodating 5 residents the staff level has increased to 3 staff until 20:30 hrs with immediate effect. Complete

Proposed Timescale: 30/06/2015

Theme: Responsive Workforce

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

There was no contingency plan developed to manage the shortfall in staff and the excessive use of agency staff workers to ensure residents receive continuity of care and support.

Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

Agency staff have been placed on roster lines to ensure continuity and a core group of dedicated staff are currently employed in the designated centre.

Proposed Timescale: 11/06/2015

Theme: Responsive Workforce

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

Staff files did not contain all documents as required under schedule 2 of the regulations.

Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as

specified in Schedule 2 are obtained for all staff.

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

All documentation as set out in Schedule 2 are being put in place.

Proposed Timescale: 30/07/2015

Theme: Responsive Workforce

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

Three staff were identified as requiring refresher training in safe moving and handling as their current certificate of training had expired.

Care staff are not trained in the administration of emergency medication in the event of a continuous seizure by a resident.

Action Required:

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

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

1. Individual staff have been identified who do not have up to date mandatory training and training has been scheduled to take place.
2. Training in Buccal Midazolam for HCA has commenced

Proposed Timescale: 30/09/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

The policy on behavioural support requires review. The policy did not reflect the model of behaviour management in which staff are trained.

There was not an evidence-based nutritional risk assessment screening tool available for use.

Action Required:

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

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

1. The policy on Behaviour support will be reviewed to reflect the change in Behaviour management.

2. A dietician has been seconded, to the Disability Service and has commenced a nutritional assessment of all the service users in the service. This commenced on a house by house basis and incorporate training for all staff in the use of the MUST-DAB assessment tool

Proposed Timescale: 06/07/2015

Theme: Use of Information

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

A directory of residents was not maintained.

Action Required:

Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

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

A Directory of Residents is now maintained.

Proposed Timescale: 01/06/2015