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A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland

Item Type	report
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Citation	Lorraine Egan, 'A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland', [report], Health Information and Quality Authority, 2016-07-18, Disability Services Report, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-04-12 03:17:57
Link to Item	https://hdl.handle.net/20.500.14765/81157

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 The Cheshire Foundation in Ireland
Centre ID:	OSV-0003445
Centre county:	Galway
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	The Cheshire Foundation in Ireland
Provider Nominee:	Mark Blake-Knox
Lead inspector:	Lorraine Egan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	10
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 inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
04 February 2016 10:50	04 February 2016 19:20

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

Outcome 01: Residents Rights, Dignity and Consultation
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 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

This was the sixth inspection of this centre. The inspection took place to assess if the provider had implemented actions as outlined in the previous inspection action plan and to inform the decision to register the centre.

As part of this inspection the inspector spoke with residents, a family member, staff and the person in charge. Residents told the inspector that positive changes had taken place since the first inspection of the centre. The family member spoke positively of the centre, staff and the person in charge.

The centre was non-compliant with 12 regulations on the previous inspection. Four of these had been addressed in line with the provider's response, five had been partially addressed but required further action to ensure compliance and three had not been addressed.

The inspector was concerned that the provider had failed to address all non-compliances arising from the previous inspection and had failed to ensure the centre was in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (hereafter called the regulations). In addition, the inspector had significant concerns in relation to the oversight of incidents in the centre and in particular the incidents of medication errors.

At the end of the inspection the inspector outlined the findings to the person in charge who said that the person in charge's line manager and the provider nominee would be informed of the findings. However, one week after the inspection the inspector spoke with the provider nominee who said he had not been informed of the findings by the person in charge's line manager.

12 outcomes were inspected with 1 judged as substantially compliant with the regulations. Eight outcomes were judged as moderate non-compliant and three outcomes were judged as major non-compliant. This resulted in non-compliances with 22 regulations on this inspection.

Area judged as substantially compliant:
- Statement of Purpose (Outcome 13)

Areas judged as moderate non-compliant were:
- Residents' Rights, Dignity and Consultation (Outcome 1)
- Contracts for the Provision of Services (in Outcome 4)
- Safe and suitable premises (Outcome 6)
- Health and Safety and Risk Management (Outcome 7)
- Safeguarding and safety (Outcome 8)
- Healthcare Needs (Outcome 11)
- Workforce (Outcome 17)
- Records and documentation (Outcome 18)

Areas judged as major non-compliant were:
- Social Care Needs (Outcome 5)
- Medication Management (Outcome 12)
- Governance and Management (Outcome 14)

The findings are outlined in the body of the report and the non compliances with the regulations are outlined in the action plan at the end of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

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

Complaints
The previous action in relation to ensuring the complaints procedure includes an effective appeals process had been addressed. However, the inspector was not satisfied the complaints procedure was effective as the timeline for responding to all complaints was not detailed and the inspector found that a complainant had not been responded to or informed of the outcome of a complaint.

The centre had identified a person working for the organisation but external to the centre as a person to whom residents could appeal the findings of a complaint at any stage. The procedure and contact details of this person were displayed in the centre.

Two complaints had been received since the previous inspection. The most recent complaint was made by a member of the public three and a half weeks prior to the inspection. Although there was evidence the complaint had been responded to, the complainant had not been informed of the outcome of the complaint.

A complaint made by a resident and the action taken was documented. However, the record did not state the complainant was satisfied with the outcome and had been informed of their right to appeal if they were not satisfied.

The inspector viewed the policy and procedure to ascertain if the organisation had identified the timeline by which complaints would be responded to. Although there was some guidance on formal or 'stage 2' complaints the policy and procedure did not specify the timeline for responding to 'stage 1' complaints.

Communication with Residents
There was a plan in place to encourage residents to use and enjoy the partially refurbished communal room. An evening of socialising was planned the evening before the inspection. The person in charge said the evening did not go ahead as there were insufficient numbers of residents interested in attending.

Improvement was required to the system to relay this information to residents. A memo had been circulated to all residents via their post boxes located at the front door of the building. The inspector spoke with a resident who did not know about the evening as they had not checked their post box until the morning of the inspection.

It was therefore not evident that all opportunities for residents to participate in activities was communicated to them in accordance with their needs.

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

There had been two admissions to the centre since the previous inspection. One admission was a short term stay to ascertain the level of support required by the resident. The second admission was for a person who was trialling the service for four months to ascertain if they would like to live in the centre on a full-time basis.

There was some written information regarding residents' admission to the centre and one resident had a copy of the service agreement on file. However, it was not evident the terms on which residents could reside in the designated centre was agreed in writing as the service agreements had not been signed by the resident or the service provider and one resident did not have a written service agreement.

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 did not inspect all aspects of this outcome.

Pre-admission assessments
Pre-admission assessments had been carried out with two residents who had been admitted to the centre since the previous inspection. Some improvement was required to ensure all relevant information was in place before a resident was admitted to the centre.

An incident report detailed a resident who said they had an allergy to a pain relieving medicine when being transferred to hospital. The resident was prescribed this medication on the prescription sheet in the centre. The person in charge told the inspector the prescription sheet had been obtained from the resident's general practitioner.

Allergies were not assessed as part of the pre-admission assessment and this had only been identified as the resident had verbally told ambulance personnel of this allergy when asked.

At the time of inspection the resident was an in-patient in hospital and the person in charge told the inspector all medication would be reviewed prior to the resident's re-admission to the centre.

Social Care Needs
It was acknowledged by the person in charge that there was difficulty in supporting residents to achieve the goals identified in their social care plans. This was also reflected in the annual review which had been carried out in November 2015.

The inspector viewed a sample of the plans and found they were comprehensive and clearly identified the resident's goals. The goals were reflective of the information a resident had imparted to the inspector on previous inspections.

A record of support provided to residents to achieve goals was maintained and it was evident that some residents were being supported to achieve the goals identified in their plans.

However, a lack of dedicated staff hours for providing social supports resulted in five residents not being supported to achieve their identified goals.

The annual review stated that some residents expressed anxiety about being unable or unsupported to work on personal goals and stated that residents who have support from Cheshire staff in relation to this expressed less concerns than those who do not have this support available to them.

This had been identified at previous inspections and was acknowledged by the person in charge and highlighted in the annual review as a challenge for the service provider.

The person in charge showed the inspector the information she was compiling to raise the issue with the centre's funding body. She said there was a meeting taking place in the near future and she was hopeful that staff hours for providing social supports would be increased.

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

<u>Communal Room</u>
The previous actions required in relation to the refurbishment of the communal room had not been fully addressed. A new floor and furniture had been put in place and the room was more 'homely' in nature.

The person in charge said that she had curtains but they were not suitable when they were put up and were subsequently taken down. She said she was sourcing curtains, soft furnishings, pictures and a large television for the room.

Equipment for residents
There was no working weighing scales in the centre. As a result residents had not been weighed since October 2015. The person in charge told the inspector a new weighing scales had been purchased however, she was awaiting the engineer to set the scales.

The requirement for a working weighing scales had been identified as part of the inspection which took place on 18 August 2015. In the action plan response the provider stated this would be addressed by 31 October 2015. The response also stated that a weighing scales would be provided in the interim and that residents' weights would be monitored.

However, this had not been addressed on this inspection and the inspector found that residents' weights were not being monitored. The person in charge told the inspector a weighing scales had been hired, however it was not effective as it was inaccurate when moved to the centre.

The inspector was concerned that the provider was not ensuring that residents had access to all required equipment to ensure their assessed needs were met.

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):
No actions were required from the previous inspection.

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

Fire Safety
Improvement was required to the system in place to ensure all residents and staff were aware of the procedure to be followed in the event of a fire in the centre. Some residents and staff had not taken part in a fire drill in the centre.

Risk Management
A resident who had moved to the centre did not have a risk management plan in place. The resident was visually impaired and required an assessment to ensure that all supports and aids required were in place.

The inspector had difficulty reading a resident's manual handling care plan. The handwriting in the plan was difficult to read and there was a risk that staff may not be able to follow the plan and ensure the required care was provided.

The response to incidents required improvement. Although incidents were documented by staff on duty the response was not consistently documented and it was therefore not evident that incidents were being responded to appropriately, corrective action implemented and measures implemented to mitigate risk of reoccurrence.

For example, an incident identified a resident's call response system as not working effectively and there was no documented response or measure implemented to ensure this resident's and all residents' call systems were working effectively on an ongoing basis.

It was therefore not evident that all systems in the designated centre for the assessment, management and ongoing review of risk were adequate.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

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

Supporting residents to make informed decisions
Residents required support and information regarding all risks to ensure informed decisions could be made in relation to a practice which was placing residents at risk.

Although this risk had been identified on previous inspections residents were not assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for protection.

Positive Behaviour Support
It was not evident that therapeutic interventions were implemented as part of the personal planning process.

Two residents required positive support plans as part of the management of behaviour that was challenging for staff. This had been identified as part of the annual review and the person in charge told the inspector these plans would be compiled utilising expertise in behaviour support.

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):
No actions were required from the previous inspection.

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

Residents assessed as 'at risk' or 'high risk' of developing pressure sores did not have corresponding specific care plans in place. It was not evident what pressure relieving devices were required by residents to mitigate the risk of pressure sores occurring.

Pressure relieving mattresses were in use for some residents and were set based on residents' weights. However, residents had not been weighed since October 2015 and therefore it was not evident that pressure relieving mattresses' were set based on residents' current weights.

The centre had purchased a weighing scales since the previous inspection. However, the scales was not in use. The inspector was told an engineer would be calibrating the weighing scales the day after the inspection.

A resident's nutritional care plan stated the resident needed to be weighed every month as part of supporting the resident with their nutritional care. In contrast the resident's 'Health Record' sheet stated the resident needed to be weighed every three months. It was not evident why these care plans differed. The inspector found there was no record of the resident's weight maintained.

The inspector therefore found it was not evident that appropriate health care, in regard to the mitigating the risk of pressure sores and weight management and review, was being provided for residents.

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):
No actions were required from the previous inspection.

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

A review of medication errors in the centre raised significant concern regarding the systems in place to ensure adequate oversight and response to errors and the system in place for ensuring staff follow procedures.

Documentation outlining medication errors, including those of administering incorrect doses or omitting medicines, did not detail that appropriate action was taken following the identification of these errors.

There was no written response to some incidences, some incidences were signed as overseen by the staff member who had made the error and many had not been responded to appropriately or in a timely manner.

Although audits were taking place on a quarterly basis the information gathered was a 'tick box' quantitative audit and did not include the oversight of medication errors.

This was brought to the immediate attention of the person in charge who was required to outline how this system would be reviewed and measures implemented to ensure residents receive medicines as prescribed and all errors are responded to appropriately going forward.

The person in charge outlined the immediate intention to put a third staff member in the centre for two hours in the morning and two hours in the evening. The inspector was told the staff member would have responsibility for overseeing medication and ensuring staff have followed the procedures. The person in charge said training would be provided for staff undertaking this role.

In addition, the person in charge said that all staff would receive updated training in medication management and said the policy on medication management was being reviewed organizationally at the time of inspection.

Improvement was required to some documentation. Some prescription sheets did not contain a photograph of the resident in line with best practice and the times of administration on a resident's prescription sheet did not match the time on the administration sheet.

Although the centre's policy stated that residents' prescription sheets would be adhered to medicines were administered at the time outlined on the administration sheet.

It was therefore not evident that the practices in the centre relating to the administration of medicines were adequately robust to ensure that medicine that was prescribed was administered as prescribed to residents.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
The person in charge emailed a copy of the centre's statement of purpose to the inspector. The statement of purpose had been reviewed after the inspection as it was dated 8 February 2016. It had been amended to address the areas identified as requiring improvement on the previous inspection.

However, the statement of purpose did not include all items required by the regulations. It did not include the arrangements for residents to access education training and employment and a description of the rooms in the centre including their size or primary function.

In addition, the description of the arrangements for residents to engage in social activities, hobbies and leisure interests and attend religious services of their choice was not adequately clear. It did not state how residents would be supported to engage in activities and attend religious services.

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

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

Oversight of incidences in the centre
The inspector was concerned that the governance arrangements were not adequate to ensure consistent and effective oversight of the care and support provided to residents living in the centre.

As discussed in Outcomes 7 and 12 the inspector was concerned that the systems in place for responding to, reviewing and mitigating the risk of reoccurrence of incidents were not effective and that the lack of oversight was placing residents at risk.

Unannounced visit
An unannounced visit had been carried out in December 2015. The persons nominated by the provider to carry out the visit had prepared a written report. However, at the time of the inspection the report had not been fully completed.

A partial visit had taken place and the remainder was marked to be completed by the regional manager (the person in charge's line manager). However, this had not been completed.

The unannounced visit report was not reflective of the inspector's findings on the day of inspection.

For example, the report did not identify that some staff and residents had not taken part in a fire drill. In addition, it did not identify that care plans for residents assessed as 'at risk' and 'high risk' of developing pressure sores did not state the pressure relieving items required to mitigate this risk.

The inspector was therefore not satisfied the plan to address any concerns regarding the standard of care and support was adequate.

Annual Review
An annual review of the care and support provided in the centre had been carried out in November 2015.

The inspector viewed a copy of the report and found it was not robust and did not outline all required improvements to ensure that the centre was in compliance with the regulations and HIQA Standards.

The inspector was particularly concerned that the review did not identify required improvements in the management of incidents, safeguarding residents and complaints.

The number and nature of adverse events/incidents in the centre had been compiled and showed that 38% of incidents related to medication, 16% related to slips/trips/falls, 12% related to health, 11% related to equipment, 6% related to behaviour and 17% related to ‘other’.

The information was quantitative and did not include an analysis of the findings and any measures required to mitigate risks in this area.

The management of incidents was not identified as an area for improvement in the annual review. It was therefore evident the annual review was not being utilised to improve care and support in regard to the response to, and management of, incidents in the centre.

Although complaints had been analysed, and data compiled, the action plan to ensure issues which required improvement were resolved was not adequate. The inspector found that the management of complaints had not adequately improved.

The information stated that 19 complaints were received and that 2 were not resolved. In relation to complainants being satisfied with the outcome of the complaint only four were identified as satisfied with seven 'Not specified/Neutral' and eight not satisfied.

In regard to the type of complaint 11 related to service delivery, 3 related to adult protection, 2 related to choice, 1 related to human rights, 1 was identified as vexatious and 1 was listed as ‘other’.

The area for improvement stated that the centre would ‘endeavour to keep residents informed at all stages and provide opportunity for appeal at all stages’.

There was no identification of follow up in regard to complaints which had not been resolved and where complainants were not satisfied.

In addition, the inspector noted that complaints and safeguarding were identified as one area and that the complaints form was used to detail allegations of abuse. This resulted in adult protection concerns not being reviewed independently in the annual review and

areas for improvement identified and responded to outside of the complaints procedure.

Given the allegations of abuse which were identified by inspectors as part of the inspection in July 2015 the inspector was concerned that the provider had not identified the protection of residents from abuse as an area for improvement in the annual review and outlined measures to ensure ongoing oversight in this area.

Systems to ensure compliance with Regulations
The inspector was concerned there was an ineffective system for ensuring that the provider implemented actions to address non-compliances identified on inspections.

Although it was evident that some actions were addressed inspectors consistently found that not all actions were being addressed in line with the provider's response to inspection action plans.

The failure to implement required improvements, sustain progress and ensure effective oversight in the centre raised concerns that the governance systems were not adequately effective.

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

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

Training
The two staff members who required training in the prevention, detection and response to suspected or confirmed allegations of abuse had received this training. The person in charge said she had made an error on the previous inspection and that these staff members had received this training prior to the previous inspection.

One new staff member required training in the prevention, detection and response to suspected or confirmed allegations of abuse. The person in charge told the inspector the staff member was assigned office duties until such time as she received this training.

Staff training was provided and there was a plan in place to address some identified training needs. However, a training needs analysis had not been carried out and it was therefore not evident that all staff training needs were being identified and responded to.

Staff working in the centre had not received training in responding to behaviour that is challenging including de-escalation and intervention techniques.

Staff members had not received training in infection control.

The person in charge told the inspector that training in responding to behaviour that is challenging and infection control had been identified by the service provider as required and that training in these areas was being developed and would be provided for all staff.

One staff member had not received training in fire prevention and using first aid fire fighting equipment and some staff members required updated training in this area. The person in charge told the inspector this training had been scheduled for December 2015 and was postponed as the trainer was ill.

Two staff members required training in food safety.

Staff files
An audit carried out in the centre identified that some staff files did not contain all information required by the regulations. The person in charge told the inspector she had assigned a staff member to address this.

Some staff working in the centre were employed by another service provider and as such were not directly supervised by the person in charge. Memorandums of understanding were agreed with the external service providers which outlined the agreement regarding supporting residents and identifying and responding to any issues identified. The person in charge held meetings with these external service providers once every four months.

The memorandum of understanding with each external service provider stated that the external provider would ensure that each staff member had evidence of Garda vetting within the previous two years, two references and evidence of appropriate qualifications. However, there was no evidence that all the information required in Schedule 2 of the Regulations would be put in place for staff employed by the external service providers.

In addition, the inspector was concerned that the person in charge and provider of this centre may not have all required knowledge of these staff members as the information was not viewed by the provider or person in charge. For example, any convictions on the Garda vetting record or any concerns raised by previous employers would not be known by the person in charge or provider.

The person in charge told the inspector that the centre hired staff through an agency occasionally. She said the agency used was approved by the organization. However, there was no system in place to ensure that agency staff had all information required by

Schedule 2 of the regulations.

Supervision of staff
The person in charge outlined the intention to commence regular formal supervision and support meetings with staff. She outlined the reason for the delay in commencing these as related to the staff union and said she was expecting the issues to be resolved in a short period of time.

Judgment:
Non Compliant - Moderate

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

Theme:
Use of Information

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

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

The person in charge told the inspector the policies were not centre specific. She attributed this to lack of time for fulfilling administration duties.

It was not evident that all staff had read and agreed to adhere to the policies and procedures. Although there was a system in place for staff to sign to acknowledge they had read and agreed to adhere to the policies some staff had not signed this.

The inspector found the system for ensuring staff were adhering to all policies, for example in relation to the response to medication errors, was ineffective.

The policy on the creation of, access to, retention of, maintenance of and destruction of records was in draft format.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland
Centre ID:	OSV-0003445
Date of Inspection:	04 February 2016
Date of response:	08 March 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation
Theme: Individualised Supports and Care **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** An opportunity for residents to participate in activities was not communicated to all residents in accordance with their needs.

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

1. Action Required:
Under Regulation 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:
Communications with residents are delivered as they are generated to individual letterboxes. This system has been reviewed and communications as they are generated are now delivered to all residents individually in their apartments. Supports where required are provided to residents by the staff member providing the communication. A local communication policy is in place to reflect same.

Proposed Timescale: 29/02/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure did not specify the timeline for responding to stage 1 complaints.

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

Please state the actions you have taken or are planning to take:
A) The Complaints Management Policy & Procedure will be amended nationally to clarify timelines for the completion of Stage 1 of the Complaints Process. Complaint has to be responded to within 3 working days

B) In the interim the PIC will implement a local procedure to ensure that all stage 1 complaints are dealt with within 3 working days and responded to. This will be detailed on local documentation and communicated to residents.

Proposed Timescale: 31/03/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A complainant had not been informed promptly of the outcome of their complaint and details of the appeals process.

It was not documented that a complainant was satisfied with the outcome of a complaint and informed of the appeals process.

3. 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:
This incident was followed up to the satisfaction of the complainant. All complaints are now followed up with the Complainant on a Complaint Feedback Form and this information is recorded and filed with the original complaint. A Local satisfaction survey is in place and being followed with each complaint. When a complainant makes a complaint they are informed of their right to appeal. An appeals process is detailed on the local appeals policy. Continued use of the satisfaction survey to be monitored through supervision meetings with staff, complaints reviews carried out by the Regional Manager each month and meetings with service users carried out by the PIC and Care Co-ordinator.

Proposed Timescale: 12/02/2016

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:
The terms on which residents shall reside in the designated centre was not agreed in writing with each resident on admission to the centre.

4. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
Terms of residency are developed in advance of new residencies. These documents had been reviewed with both individuals. Both individuals were in possession of their written documentation at the time of the inspection however signed copies were not available for the inspector. For one resident this is now signed and in place.

The second resident had a placement for a defined period of time; this residency has since completed. This individual had received a letter of offer outlining specific terms under which the residency was available, while this had been reviewed with the individual and their family the letter was not signed by the resident.

The Person in Charge shall ensure for all future residents that all documentation is reviewed and signed by any new residents in advance of their residency commencing. Where a short term or trial residency is on offer as was this incident, the Person in Charge shall ensure that a Short Term Specified Tenancy Agreement is in place in advance of the residency commencing.

Proposed Timescale: 08/03/2016

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:
The assessment, carried out prior to admission to the designated centre, was not adequately comprehensive.

5. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
The pre admission assessment document has been amended to include information on possible allergies.

Proposed Timescale: 05/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no arrangements in place to meet the assessed social care needs of all residents.

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

Please state the actions you have taken or are planning to take:
The following social supports are currently in Galway Cheshire.

A) A Social Supports Facilitator has developed Personalised Goals Plans with all residents.

B) Each resident in Galway Cheshire has access to social supports either from the Provider or in some cases from other Providers. No resident in the centre is without social supports access of up to 15 hours per week and delivered according to their wishes and needs during a particular week.

C) The PIC/Provider has submitted a proposal to HSE around the operation of the Social Support service locally, which, if accepted, would increase oversight and Provider involvement in all social support services within the centre. The proposal was submitted

and discussed at an operational meeting on 16th March 2016. Further discussion is planned on 23rd March 2016.

Following review the HSE have accepted Social Supports Facilitator will be a fulltime position of 35 hours weekly. This will commence as of 01.05.16. Additionally the Social Supports Facilitator will be positioned to oversee the Social Support Plans of all residents including those who receive their supports from external service provider thereby allowing the Service Provider oversight of all Personal Social support Plans. To be fully active by May 31st.

Proposed Timescale: 31/05/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no working weighing scales in the centre.

7. 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:
This has been addressed and the Centre has working weighing scales.

Proposed Timescale: 10/03/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The communal room had not been fully redecorated.

8. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
Soft furnishings and wall hangings / paintings are being purchased. The Registered Provider is purchasing a number of seating options and a music centre and large television for the room. Completed.

Proposed Timescale: 11/03/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

9. 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) Adverse Events are reviewed daily, each week Adverse Events are collated and sent to the National Health & Safety Officer for review. The Regional Manager completes a documented review of adverse events each month and communicates with the PIC, Health and Safety Officer, Head of Clinical Services and Head of Operations on any areas of concern.

B) Hand written Manual Handling Plans, placed as a temporary measure have been replaced with printed Manual Handling Plans. Completed

Proposed Timescale: 29/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents and staff members had not taken part in a fire drill in the centre.

10. 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:
Any residents and staff who have not taken part in a fire drill in the past 6 months have been scheduled to attend a pre-planned fire drill. This action has been completed for the resident who had not taken part in the fire drill. 31.03.16. This action is pending with one staff member and will be addressed on the next scheduled fire drill 02.05.16.

Proposed Timescale: 02/05/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Therapeutic interventions were not implemented as part of the personal planning process.

11. 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:
The Registered Provider is currently investing in up skilling staff in the area of Positive Behavioural Supports. The PIC will attend and complete a Train the Trainer Course in Positive Behavioural Supports. This training will be complete 29.04.16. On completion of this Positive Behavioural Support Plans will be developed as appropriate for the two residents who require them. Care Support Staff will receive training in Positive Behavioural Supports when the module is completed for delivery. Staff have to date received Communication and Conflict Training, delivered 18.02.16.

Proposed Timescale: 15/05/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for protection.

12. Action Required:
Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Please state the actions you have taken or are planning to take:
The PIC met with all residents individually and discussed security in the building and best practice in relation to Home Safety. 21.03.16 Discussions covered;
- Locking doors
- Use of keys, potential loss of keys
- Safe practices if away from the apartment.
- Outside lighting
- How to respond to suspicious activity
- How to respond to strangers calling
- The use of CCTV in the building
- Shared living space and the shared responsibility of securing the building

The PIC has liaised with the local Garda Station and is scheduling a date for Community Guard to meet with residents to further discuss the area of safety & security in the home. Provisional date is 13.04.16

Proposed Timescale: 13/04/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that appropriate health care, in regard to the mitigating the risk of pressure sores and weight management and review, was being provided for residents.

13. 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:
A) Care Plans for each resident have been reviewed to ensure all plans identify the equipment used by each resident to mitigate risk of pressure sores. Where appropriate each plan details the requirements for use of or setting of the equipment. Care Plans are reviewed 6 weekly or as required. This was completed 08.04.16.

B) Resident's weights have been checked and pressure relieving equipment settings have been assessed in line with same and recorded. This was completed by the Nurse and Service Manager by 8th April 2016. Weights are checked monthly.

C) All weights will now be recorded monthly by the Nurse/Care Co-ordinator and reviewed with the Regional Clinical Partner and any necessary changes made to Waterlow/MUST/PEEP assessments and plans etc. including any required alterations to pressure relieving equipment. Any necessary changes in individual plans will be documented by the Nurse/Care Co-ordinator. The PIC will review these with the Nurse on 6 weekly basis.

D) On hospital discharge or as healthcare needs change each resident's care plan will be reviewed and amended to reflect the changes required. In addition this information will be recorded on the handover sheet to ensure that all staff are aware of the changes.

E) The Care Coordinator and PIC are has developing a Weekly checklist of all Clinical service requirements, this will be completed weekly and reviewed each week for the previous week at a weekly Planning Session between Care Coordinator, Senior Care Support Worker and PIC. This checklist will commence from May 9th.

Proposed Timescale: 09/03/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The practices relating to the administration of medicines were not adequately robust to ensure that medicine that was prescribed was administered as prescribed to residents.

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

Please state the actions you have taken or are planning to take:
a) All staff will receive full Medication Management Training before May 11th 2016. This training is based on the new National Medication Management Policy. This training was not available until this date as the policy was being finalised and qualified staff to deliver it were unavailable.

b) A review of Medication errors has been completed within the service. Based on the findings of the review a tailored medication review session has been designed for delivery to all staff. This session will be delivered by a qualified nurse following the delivery of full medication management training as above.

c) As an interim measure the Person in Charge has allocated one extra staff member to the administration of medications during peak time from 8am – 10am. This staff member is designated to this task solely. Daily medications outside of this time are administered by staff on duty as this is outside of peak service requirements and rostered staff have availability for this task. Night time medications are now the designated responsibility of the Night Duty Staff member. Implemented on 4.02.16 . This measure continues to be in place.

d) The Person in Charge & the Care Co-ordinator have implemented a Medication error review which is completed daily and recorded by the, Service Manager, Care Co-ordinator or the Senior Care Support Worker. Medication errors where they occur are recorded individually for each staff person on their personal tracker file. Follow-up action on each error is carried out and documented in this file as appropriate. This measure was implemented 6.02.16 and ensured an immediate response to errors from this date.

e) The Person in Charge shall hold a two weekly review of medication errors with the Care-Co-ordinator. The review will look at recording, follow-up and management of medication errors in line with Cheshire Irelands policy, reviews will be documented.

f) In the event of an error by the Care Co-ordinator this shall be forwarded by the Person in Charge to the Provider's Regional Clinical Partner and to the Head of Clinical Services for clinical review. Following review appropriate action will be taken.

g) Photographs for both MAR Sheets and internal Kardexes have been updated to both documents on 9.03.16

h) A review of Kardex administration times versus MARS administration times has been completed and information now correlates. Implemented on 4.03.16. This is reviewed weekly on medication checks.

i) A new Medication Management Policy and Extensive Standard Operating Procedure have been developed by the organisation which includes local procedures. Within the new documentation is an updated procedure for the management of all medication variances and errors which includes all meds errors being reported up to the Head of clinical Services/ This policy has been approved and will be rolled out nationally. Currently the Care Coordinator is developing an Action Plan for the implementation of this for the local Service. Action Plan for implementation will be completed by 31.05.16.

j) Included in this policy is revised and enhanced training for staff which will take place by May 11th for Galway staff. It also includes a new system of audit – in service monthly audits of general medication management and medication variances as well as organisational 6 monthly audits of general medication management and Quarterly audits of medication variances.

Proposed Timescale: 31/05/2016

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 include the arrangements for residents to access education training and employment and a description of the rooms in the centre including their size or primary function.

The statement of purpose did not clearly state how residents would be supported to engage in social activities, hobbies and leisure interests and attend religious services of their choice.

15. 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 has been updated to include above information.

Proposed Timescale: 06/02/2016

Outcome 14: Governance and Management
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The management systems in place in the designated centre were not ensuring that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. **16. Action Required:** Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. **Please state the actions you have taken or are planning to take:** a) Adverse Events are reviewed daily, each week Adverse Events are collated by the PIC and sent to the Health & Safety Officer for review. The Regional Manager completes a documented review of adverse events each month and communicates with the PIC, Health and Safety Officer, Head of Clinical Services and Head of Operations on any areas of concern. b) The Registered Provider is currently undertaking a national review of management systems for all services with a view to implementing a robust system of checks and measures which will be standardised across services and address areas such as auditing, accountability, monitoring and evaluation of services.
Proposed Timescale: 30/04/2016
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The annual review of the quality and safety of care and support in the centre did not identify that some aspects of care and support were not in accordance with standards. **17. 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:** A) This was the first such review of the service and the review tool will be revised to reflect the findings in this inspection. B) This review took a quantitative approach to gathering of data and will be revised with this in mind so that future formats will include a qualitative action for each area of analysis with specific actions to address concerns.

C) Additionally The Registered Provider is currently undertaking a national review of management systems for all services with a view to implementing a robust system of checks and measures which be standardised across services and address areas such as auditing, accountability, monitoring and evaluation of services.

Proposed Timescale: 30/04/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The unannounced visit to the designated centre had not been fully completed, was not reflective of all aspects of the safety and quality of care and support provided in the centre and the plan in place to address any concerns regarding the standard of care and support was therefore not adequate.

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

Please state the actions you have taken or are planning to take:
The unannounced audit has been completed with a further unannounced visit by Cheshire Ireland Quality Partner external to the service on 26.2.16: A completed audit report has been complied. A second audit is due for completion before 30.06.16 and the schedule of unannounced visits has been submitted to the Authority by the Provider.

Proposed Timescale: 30/06/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff files viewed did not contain all information specified in Schedule 2.

The information specified in Schedule 2 was not in place for staff working in the centre, staff employed by external service providers and for staff hired through an agency.

19. 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:
A) Staff Files have been audited and gaps identified. Staff members will be required to provide the relevant information specified in Schedule 2 and this will be included in their staff files. Staff files will be audited once per quarter to ensure all information is kept up to date. This matter is ongoing, there are a number of staff who are collating requested information, an extended deadline for provision of May 13th has been offered. Failure to provide requested documentation post this date will be managed as a disciplinary matter.

B) The Agency utilised for cover when required has provided the Person in Charge with a document which records their compliance with the items required in schedule 2.

C) The PIC will contact the three external agencies providing supports in the centre and request copies of information as required in schedule 2 of the regulations for any staff providing supports within the centre. This action has been completed with response received from one of the external agencys outlining their concerns with our request.

Proposed Timescale: 25/03/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training needs had not been analysed and it was therefore not evident that all staff training needs were being identified and responded to.

Staff members had not received training in responding to behaviour that is challenging including de-escalation and intervention techniques.

Staff members had not received training in infection control.

One staff member had not received training in fire prevention and using first aid fire fighting equipment and some staff members required updated training in this area.

Two staff members required training in food safety.

One staff member required training in the prevention, detection and response to suspected or confirmed allegations of abuse.

20. 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:
A) Training Needs for each Service are developed annually in consultation with the National Learning and Development Manager. This process forms the basis from which training is delivered in the Centre. Specialist Training requirements may be identified at

this time, alternatively specialist training requirements can be met within the service as they are required, dependent on individual service requirements.

B) Care staff members have received Communication & Conflict Training 18.02.16. The PIC will complete FETAC Train the Trainer Positive Behavioural Supports Training, 27th – 29th April. Following this the PIC will be available as a trainer for staff members in Positive Behavioural Supports.

C) The Fire prevention training including use of fire-fighting equipment will be provided to the relevant staff members. This is complete, all staff are up to date in fire training 16.02.16
.
D) Food safety training will be provided to the two staff members. Care Coordinator & Senior Care Support Worker will attend training 27.04.16. Two Care Support Staff are unable to attend this session and will be scheduled for the next available session.

E) Adult Protection training will be provided to the staff member. Completed.

F) Infection Control Training – a training programme is currently in development and will be available for training to commence from 11/04/16. Training Programme content has been developed and comprises of 6 modules (listed below). The Care Coordinator will delived the first 3 modules in June and the 2nd 3 modules in July.
• Understanding the Chain of Infection & Standard Precautions
• Hand Hygiene
• Use of PPE's
• Management of Exposure
• Healthcare Waste Management
• Environmental Hygiene

Proposed Timescale: 31/05/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system for ensuring staff were adhering to all policies was ineffective.

The policy on the creation of, access to, retention of, maintenance of and destruction of records was in draft format.

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

Please state the actions you have taken or are planning to take:
A) The policy on the creation of, access to, retention of, maintenance of and destruction of records has been finalised by the Registered Provider.

B) Policies will be reviewed with staff at Team Meetings and in individual support sessions.

C) Staff are required to sign read and understood forms to ensure understanding. Adherence to this will be monitored by the PIC at one to one support meetings with staff. Ongoing monitoring will take place through one to one meetings.

D) Where there is a breach of staff adhering to policy the PIC/PPIM will review the incident with the staff member concerned. Follow up action will be carried out as appropriate, including advice and support, retraining and disciplinary procedure as required.

E) Any area of ongoing concern will be communicated by the PIC to the Regional Manager/Provider.

Proposed Timescale: 31/03/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies were not centre specific.

22. 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:
Policies will be reviewed, and individualised so as to be centre specific where required.

Proposed Timescale: 16/05/2016