

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cherry Orchard Hospital
Centre ID:	OSV-0003730
Centre county:	Dublin 10
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Marie Byrne
Support inspector(s):	Ciara McShane; Thomas Hogan
Type of inspection	Unannounced
Number of residents on the date of inspection:	27
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 2 day(s).

The inspection took place over the following dates and times

From:	To:
31 May 2018 08:30	31 May 2018 16:00
31 May 2018 08:30	31 May 2018 12:00
31 May 2018 08:30	31 May 2018 16:00
01 June 2018 09:10	01 June 2018 13:00
01 June 2018 09:10	01 June 2018 13:00

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 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the sixth inspection of this centre following the submission by the provider of an application to register the centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. As a result of the concerns during previous inspections of this centre, notices of proposal to cancel the registration and refuse the renewal of registration of the designated centre were issued. A representation document was submitted to the Health Information and Quality Authority (HIQA) by the registered provider following the issuing of the notices of proposal. A further inspection was completed to ascertain if the provider had implemented the measures outlined in the representation and the action plan from the previous inspection and to establish if progress was impacting positively on residents' lives.

Subsequent to this the provider was required to submit a further revised governance plan outlining how they would come into compliance. As part of this plan the representative of the registered provider was required to submit monthly assurance reports to HIQA for the duration of the six month regulatory plan. Following this another inspection was completed and the inspectors did not find that significant progress had occurred to bring about positive changes for residents in the centre.

This inspection followed up on the actions from the most recent inspection and also reviewed and verified the progress outlined in the providers' monthly assurance reports.

How we gathered our evidence:

During the inspection, inspectors met and spoke with nine residents, the registered provider representative, the person in charge, and staff members. Inspectors viewed documentation such as personal support plans, policies and procedures, risk assessments and incident reports. The registered provider representative and newly appointed person in charge facilitated the inspection

Description of the service:

The designated centre is based in Dublin and operated by the Health Service Executive (HSE). The centre consists of two buildings in close proximity to each other, within a hospital campus. Care is provided in the centre for 27 residents over the age of 18, both male and female with a disability, including six respite beds. Support is provided to residents over a 24 hour period by registered nurses and healthcare assistants. In addition a social care worker has recently been recruited and commenced in post in the centre.

Overall judgments of our findings:

In line with the findings of the last inspection there was evidence of progress; however, this progress was not significant enough to bring about compliance with the regulations or to improve residents' lived experience. Thirteen outcomes were inspected against during the inspection. Nine outcomes were found to be major non compliant and four to be moderate non compliant with the regulations. The inspectors found that residents' privacy and dignity was not respected at all times in the centre due to the layout, design and practices in the centre. Increased levels of non compliance were found since the last inspection in relation to healthcare and workforce. Residents continued to have limited links with and involvement in their local community. A new care planning system was in its infancy and works had commenced to develop social goals for residents. However, improvements were still required to ensure there was a comprehensive assessment of residents' health, personal and social care needs was in place for each resident. There was an increased presence of the provider representative and other members of the management team since that last inspection including more audits. However, improvement was still required in relation to the day-to-day monitoring and oversight of the centre. Areas of progress and findings of this inspection are discussed within the body of this report and the regulations which are not being met 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:

Overall, the inspectors found that residents' privacy and dignity were not upheld at all times within the centre. There were improvements noted in relation to consultation with residents such as residents' meetings and the introduction of a new advocacy group. However, institutional type practices remained and the inspectors found that routines in the centre remained task orientated which was impacting residents negatively. Residents' privacy and dignity continued to be compromised due to the design and layout of the premises including multiple occupancy bedrooms. Also, some documentation reviewed in the centre was not found to be person-centred. The provider had put measures in place to complete two of the six required actions following the last inspection, four actions remained outstanding. The inspectors acknowledge that the proposed timeframe for these actions by the provider had not passed.

Residents' meetings were occurring in the centre, and it was clear that each month they were evolving. They were becoming more person-centred and actions were being developed. Residents were chairing these meetings and suggesting required improvements in the centre such as more community participation, more activities like movie nights and greater access to transport to take part in community based activities. There was evidence that residents' family members were invited and in attendance at some of these meetings. More information was available in the centre for residents in relation to advocacy support and a new social worker had just commenced in the centre and had started a residents' advocacy group.

The provider representative had commenced audits of the quality of interactions

between residents and staff in the centre. They had completed four of these audits to date, and plans were in place for another two. Once the six audits were completed plans were in place to summarise the findings and develop an action plan. The provider representative informed the inspectors that immediate feedback was given during these audits to staff when required.

The residents' survey which was completed in January and February of 2018 had been summarised and a group tasked with reviewing the required actions. On reviewing the action plan from this group some of the actions were in their infancy and yet to have an impact for residents, and there were no clear dates for when actions were due for completion for some of the actions.

Inspectors found that the privacy and dignity of residents continued to be negatively impacted on due to multiple occupancy bedrooms. Some residents did not have adequate storage for personal belongings in shared bedrooms. Communal bed linen was in place in the centre which was laundered by an external company. Individual televisions were being installed for residents and wireless headphones being sourced to consider other residents in the room.

Routines in the centre continued to be task orientated. Due to planned and unplanned leave in the centre the availability of continuity of care for residents was being negatively affected. Staff in the centre were spending the majority of their time looking after residents' personal care and had limited time to engage in meaningful interactions and activities with residents. Inspectors found that overall residents did not have opportunities similar to their peers and that some residents had limited access to their local community. Some residents did not have opportunities to participate in activities that were meaningful, and in line with their needs, interests and capacities and detailed further in this report.

There was a noted decrease in foot traffic in one of the premises in the centre since the last inspection. The provider was in the process of getting a new fob and pager system on the front door in the centre. Residents who wished to and staff in the centre were proposed to have access to fobs to access and egress the centre. As these works were in progress during the inspection inspectors continued to observe people entering one premises in the centre without ringing the doorbell, or ringing the doorbell and walking straight in. Inspectors observed the front door open in the other unit for a 45 minute interval and people entering without ringing the doorbell.

An area specific procedure was in place to provide guidance to staff in relation to residents' finances. A safe was in place in the centre and some residents' money was held here securely. The provider outlined had commissioned a retrospective financial audit into residents' accounts from 2013 and this identified that a number of residents required to be reimbursed following this.

The provider representative had completed a complaints audit in the centre in April 2018. In line with the findings of this inspection they identified issues relating to follow up and learning from complaints. They also identified the need for staff training and a requirement for the complaints leaflet to be adapted to make it more accessible for some residents. Since the last inspection improvement was noted in the complaints log

in the centre, which was new and on trial. However, on reviewing a number of incident reports in the centre which involved complaints by residents, there were no corresponding complaints logs in place. Inspectors found that there was a complaints policy and protocol in place which was for the entire for organisation. There was no local complaint officer identified for the centre.

Judgment:

Non Compliant - Major

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):

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

Findings:

The inspectors reviewed a number of contracts of care and found that they did not contain all the required information required by the regulations. The provider had identified a date for the completion of review of residents' contracts of care. This date had passed and the contracts had not been reviewed and updated.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Overall, the inspectors found that each residents' care and support needs were not fully assessed. Some residents had limited opportunities to participate in meaningful activities, appropriate to their interests and preferences. The inspectors acknowledged that there had been an increased focus on residents' social care needs in the centre and a social care worker had recently been employed in the centre. However, social care goals were in their infancy and required further development. Inspectors found that none of the four actions identified by the provider following the last inspection had been completed. However, inspectors acknowledged the timeframe for completion of some actions had not yet passed.

The provider was in the process of adapting a social care model in the centre and had introduced new personal plans based on this. However, inspectors found that the review of personal plans were in the infancy stage and improvements were still required in relation to ensuring they included a comprehensive assessment of residents' health, personal and social care needs. Residents' had a number of assessments in place; however, they had no overarching assessment of need in place. The majority of residents and their representative had recently attended a personal planning meeting and had been involved in the review of their personal plans.

The inspectors found that some work had been completed in relation to residents' social goals. However, there was insufficient evidence to show that these goals were meeting residents' needs or progressing in a timely manner. A number of residents' goals reviewed which were developed four months ago, had no progress documented in them. There was now a tracker document in place for residents' goals, but this was not being consistently completed for all residents. Some residents' personal plans were not available in a format which was accessible to them. The inspectors acknowledge that some staff were starting to make residents' goals available in an accessible format.

An art therapist was now available in the centre and working with residents on an individual basis and in groups. Residents who spoke with the inspector valued these sessions and would like more of them. A new activity record was in place in the centre which recorded residents' activities morning, afternoon and evening. On reviewing these records there was an increase in home and community based activities for a number of residents since the last inspection such as going to day services, going to the local church and library, attending community groups, going to the local shopping centre and attending computer classes. However, the inspectors reviewed three residents' activity records where no activities were recorded outside of the centre over a two week period. One of these residents requires the assistance of an agency staff to take part in some activities and had no access to this staff for two weeks due to issues with a purchase order. There was a marked decrease in this resident's activity levels during this period.

Inspectors spoke with a number of residents during the inspection who highlighted that transport was a barrier to engaging in meaningful community based activities. One resident described waiting three hours for a wheelchair accessible taxi which resulted in their planned activity being cancelled, and two other residents described waiting a

prolonged period the day before to get home from a local shopping centre due to lack of availability of transport. This was also highlighted in the recent residents' survey and at recent residents' meetings. The provider had recognised this and had secured quotes for transport for the centre and was in the process of securing funding for this.

A number of residents' personal plans had not been reviewed to ensure they were effective, or updated in line with residents' changing needs. In addition the inspectors reviewed a number of residents' personal plans, which were reviewed by the multidisciplinary team during case review meetings and found that decisions relating to residents were not completed in a person-centred manner or in consultation with residents. Care plan audits had commenced in the centre and two were completed at the time of the inspection. Learning from these audits was shared with relevant staff at the time of the audits.

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:

Overall, the inspectors found that the design and layout of the premises was not fit for purpose, and was not meeting residents' individual or collective needs in a comfortable and homely way. Inspectors found that none of the actions identified by the provider from the previous inspection had been completed. Inspectors acknowledge that the timeframe identified by the provider for completion of some actions had not yet passed.

In line with the findings of the last inspection, for the most part inspectors found that there was suitable equipment, aids and appliances in place to support residents. However, one resident who required a wheelchair to access the community remained without this chair. The person in charge outlined that the chair had been ordered and was due to be delivered in a number of weeks.

The centre was found to be clean throughout during the inspection. The inspectors found that the requirements of schedule 6 of the regulations were not being met in the centre. The centre remained compromised in relation to the layout and design in

meeting residents' needs. Residents' privacy and dignity was still being compromised in relation to multiple occupancy bedrooms. These bedrooms were not of a suitable size or layout to meet residents' needs. Residents did not have adequate storage space for personal items. The provider representative outlined plans to change multiple occupancy rooms to single occupancy rooms. These plans were starting to be explored but had not progressed to a stage where actual works were planned.

There were areas of the centre in need of painting and repair. The provider had recently upgraded a number of bathrooms and had similar plans for the remaining bathrooms in need of repair. There was evidence that residents had been consulted with and involved in choosing paint colours for the centre. However, these works were on hold in line with the providers' plans to change multiple occupancy rooms to single occupancy rooms. Some improvements had been made to the centre to make it more homely such as pictures and photos on walls in the centre.

In line with the findings of the last inspection the provider had identified that a new build would be completed by 2021 for older persons services, and that this in turn would facilitate the relocation of one of the units in this centre to the premises previously used by older services.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Overall, inspectors found that the health and safety of residents, visitors and staff in the centre was not being fully promoted or protected. Improvement was noted in relation to infection prevention and control and fire management systems in the centre since the last inspection. Risk management systems had been further developed. However, there was improvement required in relation to the risk register, on-going review and management of risk in the centre, and learning from incidents in the centre. Inspectors found that four of the seven actions identified by the provider following the last inspection had not been implemented.

Since the last inspection an updated risk management policy and a risk register was available in the centre. Inspectors found that the new risk management policy referred to but did not guide staff practice in relation to, unexplained absence of a resident,

accidental injury of residents/visitors/staff, the measures and actions in place to manage aggression and violence and measures in place to manage self-harm. Also, the risk register required improvement in relation to control measures, additional control measures, person responsible, and the risk ratings. The inspectors found that the risk register referred to control measures being in place which were not actually in place such as one stating that all staff in the centre were Garda vetted. In addition, some residents' individual risk assessments contained language which was not found to be person-centred and inaccuracies were found in a number of risk assessments such as different residents names in the same risk assessment. The provider had provided training on the risk management policy and 84% of staff had not completed this training.

Inspectors found that improvement was still required in relation to suitable arrangements for identifying and learning from incidents in the centre. The inspectors reviewed a number of incident reports in both units in the centre and found that they had neither been appropriately followed up on, nor was there evidence of any learning following them. Incident report training had been provided by the provider and 66% of staff in the centre had not attended this training.

Improvements had occurred in relation to fire management systems including fire containment in the centre. Works had been completed by an external company to assure the provider in relation to regulation 28. There was suitable fire equipment provided and adequate means of escape and fire exits which were unobstructed. Fire evacuation procedures were clearly displayed in the centre and the provider had identified further improvement was required to make these clearer. These new procedures were being printed at the time of inspection. There was documentary evidence that the fire alarm and fire equipment had been serviced in line with the timeframes identified in the regulations. On reviewing training records improvement was required in relation to staff fire training in the centre. 14% had not completed fire safety awareness training, 9% had not completed fire evacuation ski sheet training, 9% had not taken part in fire drills, and 11% had not completed fire extinguisher practical training. Improvement was also required in relation to staff training and fire drills in the centre. Fire drills were occurring regularly in the centre. However, contradictory information was contained in some of these fire drills including the time it took to evacuate, and in detailing how many staff and residents took part in the drills. It was also not clear from reviewing the records whether all residents were safely evacuated from the centre during the drills. There was limited evidence of corrective actions or learning following these drills.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided

with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

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

Findings:

Overall, inspectors found that appropriate measures were not in place to safeguard residents and protect them from abuse. All residents were not in receipt of behavioural and therapeutic support to promote a positive approach to their behavior that challenges. The arrangements to support residents with managing their behavior was not sufficient. Inspectors found that none of the actions identified by the provider following the last inspection had been put in place.

The inspectors met with the clinical nurse specialist for behavior who discussed progress of the new responsive behavior support pack which they had developed and were trialing prior to the last inspection. There were now two of these responsive behavior support packs completed for two residents identified as requiring support to manage their behaviour. The inspectors acknowledge this work and particularly the impact it has had for one resident; however, a number of residents identified as requiring behavior support assessments and plans did not have these plans in place. Therefore, there was insufficient guidance in place for staff to support residents with their behavior support needs.

The inspectors reviewed training records and found that although there had been a slight improvement in the number of staff who had received safeguarding training, 17% staff still had not completed safeguarding training. The inspectors spoke with a number of staff who demonstrated an understanding of their responsibilities in relation to responding to and reporting allegations of abuse. In line with the findings of the last inspection plans to train designated officers in the centre had not been completed. The designated officer in place had not received training to carry out their role as designated officer. The inspectors met with the designated officer who showed the inspectors the new safeguarding register which was now in place. They also discussed the newly developed residents' group which they facilitated. This group had planned meetings every four to six weeks in residents' home to explore and discuss all aspects of safeguarding.

Inspectors reviewed a number of residents' intimate care plans and they were found to guide staff practice to support residents. However, during the inspections a number of staff described one residents' intimate care needs and these were not reflected in their intimate care plan.

On reviewing incident reports in the centre, inspectors found a number of allegations of abuse which had not been fully investigated or followed up on. The inspectors found

that the management of these allegations and the support for the residents post the allegations was not satisfactory. In response to these findings the designated officer arranged a meeting with relevant members of the multidisciplinary team and a representative from the national safeguarding team. The agenda items for this proposed meeting included discussions relating to what constitutes a safeguarding concern, the reporting process, preliminary screenings, safeguarding plans and each members' responsibilities in relation to safeguarding.

Inspectors requested an update in relation to staff members' Garda vetting in the centre. There was evidence of improvement in the numbers of staff who were Garda vetted. However, 37% of staff in the centre did not have their completed Garda vetting report in place.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

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

Findings:

On reviewing incident reports in the centre, the inspectors found an allegation of abuse which had not been notified in line with the requirement of the regulations.

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):

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

implemented.

Findings:

Overall, the inspectors found that residents had limited opportunities for education, training and employment. It was evident that efforts were being made in the centre for some residents to have opportunities for new experiences in relation to social participation and education and training. However, these experiences remained limited for some residents and for others they were in the early stages of development and yet to have an impact. Inspectors reviewed a number of residents' personal plans and found that there was no robust system in place to establish residents' educational, employment or training goals.

Two residents at the time of inspection were attending computer classes and one resident was being supported by an occupational therapist to get assistive technology to support them to attend a computer class in the future. A working group has been developed to progress the recommendations made by residents in the recently completed survey. Some of the actions from this group have been identified as reviewing housing options for residents in the local community, sourcing transport for the centre, and supporting residents to get a job.

From reviewing residents' social goals and activity planners there was limited evidence of meaningful community based activities for some residents. This is discussed further in the body of this report.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Overall, inspectors found that residents were not being fully supported to enjoy best possible health. On the second day of inspection, inspectors found deficits in relation to the assessment and management of some residents' nutrition and hydration needs. Assurances were sought from the person in charge in writing that residents' nutrition and hydration needs were being appropriately assessed and that plans were in place to support them with these needs. These assurances were received by the inspectors post the inspection.

The inspectors found that some residents did not have healthcare plans in place in line with their assessed needs. Also, some healthcare plans had not been updated in line with residents' changing needs. These plans had also not been reviewed by members of the multidisciplinary team. One residents' nutrition and hydration care plan referred to a percutaneous endoscopic gastrostomy (PEG) tube. However, this resident now had a nasogastric tube fitted. This residents' care plan still referred to the PEG tube and had not been updated within the 12 months that a nasogastric tube was in place.

On reviewing records in the centre there were a number of residents' experiencing unintentional weight losses. For one resident this was almost 10kg in the preceding six months. A number of residents who were identified by staff as being at risk of dehydration or malnutrition did not have appropriate assessments or care plans in place, and there was no system in place to record their food and fluid intake. On the second day of inspection a food and fluid intake record was in place for one resident which showed that they had been assessed as requiring 1,675ml of fluids; however, it was recorded that they had only received 1,525ml of fluids. This resident was prescribed 875ml of a therapeutic food; however, it was recorded that they had only received 525ml of this therapeutic food. There were no specific records kept with regard to residents on enteral feeds. Their nutritional and fluid intake was recorded on the drug recording sheets in the unit.

The inspectors found that some residents did not have access to allied health professionals in line with their assessed needs such as those experiencing unintentional weight losses who did not have access to a dietician for a number of months. The provider had secured funding for this role and was in the process of recruiting to fill the position. Assurances were given by the registered provider representative post the inspection that a private dietician would be sought for those residents assessed as requiring immediate review.

The inspectors found that improvements had been made in relation to how residents were supported during meal times, and to their access to drinks and snacks. A new snacks and drinks station was in place in one of the units. In the other unit residents who required access to the kitchen for food and snacks could do so. Accessible menu boards and menu options were on display. Residents are supported by catering staff to choose their meals the day before, and if they changed their mind on the day, there was another option made available which was displayed on the menu board.

Judgment:

Non Compliant - Major

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Overall, inspectors found that residents were protected by the centres' policies and procedures for medication management. Although, there was improvement required to documentation for as required medicines (PRN), and to residents' capacity to self-administer assessments. One of the three actions identified by the provider following the previous inspection had been completed.

Medicines in the centre were supplied by a central pharmacy on the campus of the designated centre and were not individually labelled for each resident.

The inspectors reviewed a sample of residents' medicines prescription sheets and found that the criteria for administration of some PRN (a medicine taken as the need arises) medicines were not clear. In addition, there were no guidance documents in place to guide staff in relation to what circumstances or how often to administer these PRN medicines.

There were assessment forms in place in relation to residents' capacity to manage their own medicines. The inspectors found that these forms did not detail how the decision was reached as to whether they had the capacity to manage their medicines, or how the decision was reached for residents not to manage their own medicines when they were deemed to have capacity.

Inspectors observed staff adhering to safe medicines management practices during the inspection. The centre operated a system where the nurse administering medicines wore a red plastic vest over their uniform, this was to ensure other staff did not disturb the nurse when administering medication. There were systems in place for the handling and disposal of unused and out of date medicines. There were systems in place for reviewing and monitoring safe medication management practices including a recent medication audit.

Judgment:

Non Compliant - Moderate

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 statement of purpose had been reviewed since the last inspection. It was found to contain all the information required by schedule one of the regulations.

The statement of purpose was not available in a format which was accessible for all residents.

Judgment:

Non Compliant - Moderate

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 inspectors found that the management systems in place were not ensuring that the service provided for residents was safe or appropriate to meet their needs. Although there were strengthened arrangements put in place by the provider representative, concerns still remained in relation to the providers' capacity to oversee the day-to-day management of the centre. A new person in charge had been identified by the provider and had commenced in post in April 2018. The provider representative had put additional systems in place to monitor the care and support in the centre such as weekly visits to the centre, additional presence of other members of the management team in the centre, the completion of a number of audits, and weekly oversight committee meetings and project team meetings. However, improvements were still required in relation to the day-to-day oversight and monitoring of the centre to ensure residents were in receipt of a good quality of care and support in the centre.

Inspectors identified while some progress had occurred since the last inspection in relation to the quality of care and support for residents these changes were yet to impact and enhance the quality of lives for residents. Significant improvements were still required in relation to ensuring residents were in receipt of safe, consistent and effective

care and support in line with their needs and wishes. The care and support for residents in the centre was not found to be in keeping with the centres' statement of purpose.

The new person in charge had responsibility for one designated centre and was working in the centre in a supernumerary capacity. They had worked in the centre for a number of years including working in the capacity as a clinical nurse manager. They were only in post as person in charge for a number of weeks at the time of inspection and had yet to implement effective systems in relation to oversight and management of the centre. In line with the findings of previous inspections the person in charge was not on the roster in one of the units.

There was an annual review of quality and safety of care in the centre and six monthly visits by the provider or their representative. However, a number of actions identified in these reviews had not been completed in line with the timeframes identified by the provider. The provider representative, person in charge and quality manager were meeting to track these actions. Some audits had commenced and some of these had plans in place to address the findings, however, some of these were at the infancy stage and had yet to bring about a positive impact in relation to residents' care and support in the centre.

Staff meetings were occurring and there was a daily handover in place. Management walk rounds were occurring and identifying some similar finding to those of this inspection. These included, highlighting the importance of the person in charge on the roster, the required improvements in fire drills and fire safety, record keeping deficits in the centre and issues relating to premises.

Effective arrangements were not in place to support, develop and performance manage all members of the workforce. There was no system in place in relation to performance appraisal for staff members. The provider had plans in place to address this but they were not in place at the time of the inspection.

Training gaps which were identified in the centre during the previous three inspections were still found to be in place during this inspection.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Overall, the inspector found that there were insufficient staff numbers with the right qualifications or skill mix of staff to meet residents' assessed needs. Residents were not in receipt of continuity of care due to a large volume of shifts being covered by agency staff in the centre. A number of staff in the centre did not have training in line with residents' needs and were not being supervised appropriate to their role.

The inspectors acknowledged that the provider had recognised the need to review the skill mix of staff in the centre. A social care worker had just commenced in the centre and a number of staff had completed, or were being supported to complete additional social care qualifications. In addition a number of staff had plans to complete further training in leadership, rehabilitation and disability studies. The provider representative described further plans to also employ a social care leader.

During the inspection, inspectors found that residents were not in receipt of adequate support and assistance and that at times residents were not being supported to engage in meaningful activities. One resident who spoke with the inspectors told them that they were going to attend a certain activity at 09:45 when inspectors spoke to them again at 12:50 they said they were still waiting to attend this activity.

There were planned and actual rosters in place which highlighted a marked increase in the use of agency staff since the last inspection. Inspectors reviewed rosters over a four week period and there were 126 shifts covered by agency staff. In addition to this agency usage, there were also occasions when there were insufficient numbers of staff on duty in line with residents' assessed need or the centres' statement of purpose. There were occasions where the centre was operating below required staffing levels such as times they were short one staff and other occasions when they were operating minus two staff. There were also occasions when insufficient numbers of nursing staff were available in the centre to meet residents' assessed needs including both days of the inspection. This was discussed with the person in charge and they told inspectors it was due to planned and unplanned leave.

There remained to be significant gaps in training which was identified and made available in line with residents' assessed needs. The inspectors reviewed the centres' training matrix and found that in one unit 76% of staff had not completed trust in care training, 86% had not completed communication with people with an intellectual disability training, 81% had not completed HSE effective complaints handling training, 62% had not completed responsive behaviour training, 48% of staff had not completed incident report training, 14% had not completed person centred planning training, 91% had not completed risk assessment training, and no staff had completed disability awareness training.

In the other unit, 86% of staff had not completed trust in care training, 70% had not completed risk assessment training, 17% had not completed person centred planning

training, 93% had not completed disability awareness training, 64% had not completed responsive behaviour training, 43% had not completed HSE complaints management training, 57% had not completed communication with people with an intellectual disability training and 71% had not completed incident report training. The training matrix was being reviewed in the centre monthly and key findings being escalated to management of the centre. The provider has recognised low training levels for health care assistants in the centre.

Judgment:

Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Marie Byrne
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-0003730
Date of Inspection:	31 May 2018
Date of response:	24 September 2018

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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

The inspectors found that routines in the centre were task orientated and this was impacting residents' freedom to exercise choice and control over their daily lives.

1. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the

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

freedom to exercise choice and control in his or her daily life.

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

Multidisciplinary team meetings have now taken place for all residents. The MDT has evaluated the effectiveness of the meetings and as a result the Social Worker is taking a lead in putting a new structure in place on how future MDT review meetings will be managed. An MDT information leaflet has been developed for residents and families to assist in their understanding of the MDT process. These leaflets are available in both units.

A New schedule of MDT meetings for the rest of 2018 will be released by 01/08/2018.

Resident meetings continue to be held on a monthly basis chaired by one of the residents. Schedule of the meeting is available on the noticeboard. Residents are encouraged to add items to the agenda. Agendas are circulated in advance. Minutes are available in the centre. The Residents meeting is a forum where residents can express their concerns, issues and to let the staff know if there are changes they want to do within the unit.

The additional social worker commenced on 17/04/18. A model of advocacy support is being developed and will be available by 31/07/18.

The project group with resident representation continues to meet fortnightly and is actively addressing some outstanding issues. This includes updates from the environmental group and actions from the resident survey group and a review of accessible information required for residents.

A daily plan is completed in each residents care plan. It provides a record of residents choice of daily activity.

A complaints audit has taken place and recommendations are being actioned. All staff were required to completed the HSEland online module and at the 06/07/2018 100% of the staff in Elm and 80% in Lisbri have completed the module with a date for the remaining 2 staff 12/07/2018.

A local complaints officer has been identified and her name and contact details are displayed within the units.

Education has been provided to all staff by an external disability provider to assist in staff completing plans of care in a person centre manner. The first session took place on 03/07/2018 and the second will take place 10/07/2018.

A Quality of Interactions Schedule is being carried weekly as part of the schedule of provider visits and will be audited on completion of 6 of the visits.

Proposed Timescale: 01/08/2018

Theme: Individualised Supports and Care

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

Residents' privacy and dignity were being compromised due to the design and layout of the premises including multiple occupancy bedrooms.

2. Action Required:

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

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

A schedule of works to reduce 2 multi-occupancy rooms to single occupancy has been drawn up. The schedule of works is as follows:

Tender Issued week ending 06/07/2018

Two weeks for tenderers to price

One week to review and award

Two weeks standstill period

After which the works contractor can commence on site

It is also proposed that one resident will move from Lisbri to Elm; following this, all long term bedrooms will have single or double occupancy.

Frosted privacy sheets have been placed on the bedroom windows facing out on to the courtyard areas.

Proposed Timescale: 30/09/2018

Theme: Individualised Supports and Care

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

Inspectors found that residents used communal bed linen which was laundered by an external company.

3. Action Required:

Under Regulation 12 (3) (c) you are required to: Ensure that where necessary, each resident's linen and clothes are laundered regularly and returned to that resident.

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

Personal laundry services are available in both houses only for residents to launder their personal clothing. For the residents who cannot launder their own clothes assistance is provided by staff on site.

Duvet covers and bed linen must comply with fire regulations; different colours and patterns for duvet covers and pillow cases are provided. The PIC is liaising with bed

linen companies for choices of colours and designs for the residents to choose from. Following consultation with Residents, bed linen will be purchased.

Proposed Timescale: 31/08/2018

Theme: Individualised Supports and Care

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

Inspectors found that residents in multiple occupancy bedrooms did not have adequate space to store their personal property and possessions.

4. Action Required:

Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.

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

A schedule of works to reduce 2 multi-occupancy rooms to single occupancy has been drawn up. The schedule of works is as follows:

Tender Issued week ending 06/07/2018

Two weeks for tenderers to price

One week to review and award

Two weeks standstill period

After which the works contractor can commence on site

When complete this will free up space for residents personal belongings/property as there will be no more than 2 residents in any long term bedroom.

Additional wardrobes will be purchased and provided to residents to ensure adequate space to store maintain clothes and personal property.

Proposed Timescale: 30/09/2018

Theme: Individualised Supports and Care

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

The complaints procedure in the centre was not available in a format which was accessible for all residents.

5. 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:

The complaints procedure is now in an age-appropriate and accessible format and is available for residents.

All staff have been asked to complete the HSE Effective Complaints Handling Module on HSELand. To date 80% of Lisbri and 100% of Elm nursing staff have completed with an action completion date of 12/07/2018.

All complaints are now being closed off by the Person in Charge to ensure oversight and resolution.

Proposed Timescale: 12/07/2018

Theme: Individualised Supports and Care

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

The inspectors found that improvement was required in relation to staff recognising what constitutes a complaint.

6. Action Required:

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

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

All staff have been asked to complete the HSE Effective Complaints Handling Module on HSELand. To date 80% of Lisbri and 100% of Elm nursing staff have completed with an action completion date of 12/07/2018.

The complaints log locally has been amended to ensure that complaints are recorded properly, staff are aware to communicate the appeals process to complainants and that outcomes are clearly documented.

All complaints are now being closed off by the Person in Charge to ensure oversight and resolution.

Proposed Timescale: 31/08/2018

Theme: Individualised Supports and Care

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

There was no local complaints officer in place for the centre.

7. 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 Person In Charge has been identified as the local complaints officer; Local protocol has been amended to indicate the appointment of a local complaint officer and signage has been erected in the units identifying the name and contact details of the local complaints officer.

Proposed Timescale: 31/07/2018

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The inspectors reviewed a number of contracts of care and found they did not contain all the information required by the regulations.

8. 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:

The Contract of Care has been revised. All residents have been supplied with the revised version. All old contracts of care have been removed from the residents files and replaced with new signed contracts. A copy of the new contract was forwarded to HIQA.

Proposed Timescale: 31/07/2018

Outcome 05: Social Care Needs

Theme: Effective Services

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

A comprehensive assessment of residents' health, personal and social care needs had not been completed.

9. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need

and circumstances, but no less frequently than on an annual basis.

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

Multidisciplinary team meetings have now taken place for all residents. The MDT has evaluated the effectiveness of the meetings and as a result the Social Worker is taking a lead in putting a new structure in place on how future MDT review meetings will be managed. An MDT information leaflet has been developed for residents and families to assist in their understanding of the MDT process. These leaflets are available in both units.

A New schedule of MDT meetings for the rest of 2018 will be released by 01/08/2018.

A Senior Dietician has taken up post since the 2nd of July and a Senior SLT commenced in May 2018

Proposed Timescale: 01/08/2018

Theme: Effective Services

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

The inspectors found that residents' social goals were not meeting residents' needs or progressing in a timely manner.

10. 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 centre continues to move towards a social care model. Consultation with residents takes place on a daily basis and also through the monthly resident meetings. A daily activities log is maintained in the resident's PCP.

Each resident's individual's goals (both social and medical) are discussed with them/their representative at the multidisciplinary meetings and an action plan developed.

All residents participate in individualised activities of their choosing. Some residents participate in activities in local community centres. A directory of activities in the local community is available in the centre for residents to access independently or with support from their key worker.

A schedule of care plan reviews is currently being put in place which will see 4 care plans being reviewed monthly by the Person in charge with support from nursing management.

Other members of the team are currently participating in person-centeredness course to develop a group of staff members who are to share strategies and processes to

implement culture changes within our services. The first meeting will analyse the understanding of person centeredness and its impact on all services. This is a 7 month exercise commencing on the 19th of July 2018.

Proposed Timescale: 31/08/2018

Theme: Effective Services

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

Some residents' personal plans were not available in a format which was accessible for them.

11. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

The O'Brien model of resident's personal plan has been implemented in partnership with Residents and their families. An accessible format is being developed for residents who require this.

Proposed Timescale: 31/08/2018

Theme: Effective Services

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

The inspectors reviewed a number of residents' personal plans which had not been reviewed to ensure they were effective.

12. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

An audit of every care plan including personal plans has been carried out; action plans are being developed based on the outcome of the audit.

Personal plans are discussed and reviewed at the 6 monthly multidisciplinary meeting where the resident's goals are discussed with them/their family.

Proposed Timescale: 31/08/2018

Theme: Effective Services

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

The inspectors reviewed a number of residents' personal plans which had not been updated in line with residents' changing needs.

13. Action Required:

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

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

An audit of every care plan including personal plans has been carried out; action plans are being developed based on the outcome of the audit.

All personal plans are currently being reviewed and will be updated in line with residents changing needs.

Proposed Timescale: 31/08/2018

Theme: Effective Services

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

The inspectors reviewed a number of residents' personal plans where, at multidisciplinary team case review meetings, decisions relating to residents were not completed in a person-centred manner or in consultation with residents.

14. Action Required:

Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Education has been provided to staff in relation to completing personal plans in a person-centred manner by an external disability service provider. Training was provided on the 3rd of July with a second date planned for the 10th of July. All staff other than those on long term sick leave will have received training by the 10/07/2018.

Proposed Timescale: 10/07/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:

The inspectors found that the design and layout of the centre was not suitable to meet residents' needs as outlined in the body of the report.

15. Action Required:

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

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

A new build plan is in place for 2021 on the site. It is anticipated that disability services will then transfer to one of the vacated units on site which will meet the requirements of Schedule 6.

HSE Estates have explored options around the design and layout of the bedrooms, 2 multi-occupancy rooms are going to be redesigned to 2 single occupancy rooms. Plans have been drawn up and went out to tender 06/07/2018.

No new admissions are being taken to the centre currently. One resident has expressed interest in moving home to her own house. This is being explored with her with help of Social Work.

Proposed Timescale: 30/09/2018

Theme: Effective Services

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

There were areas in the centre in need of painting and repair including a number of bathrooms which needed repair and upgrade and areas of the centre which required painting.

16. Action Required:

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

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

A schedule of works for general repairs will be drawn up with the Maintenance Manager and PIC.

PIC, OT and maintenance Manager will ensure general repairs are completed. PIC and OT will develop a schedule of works and send to the Maintenance manager by 13/07/2018. The OT has contacted a contract gardener to help improve the outdoor environs of Lisbri and Elm.

It is envisaged that once the garden is cleared, a gardening group will be established for residents to partake in the designing of the outdoor space, this will be led the OT.

Painting of Lisbri will commence on the 16th of July 2018. Residents were involved in colour choices and have been informed of impending works.

Proposed Timescale: 30/09/2018

Theme: Effective Services

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

The inspectors found that the requirements of schedule 6 of the regulations were not being met in the centre as outlined in the body of this report.

17. 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:

A new build plan is in place for 2021 on the site. It is anticipated that disability services will then transfer to one of the vacated units on site which will meet the requirements of Schedule 6. HSE Estates have explored options around the design and layout of the bedrooms, 2 multi-occupancy rooms are going to be redesigned to 2 single occupancy rooms. Plans have been drawn up and went out to tender today 06/07/2018.

Frosted covers on bedroom windows are in place to increase the privacy in bedroom windows.

No new admissions are being taken to the centre currently. One resident has expressed interest in moving home to her own house and this will be explored with her with support from Social Work.

Proposed Timescale: 31/12/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The inspectors found that measures and actions to control risks in some risk assessments were not appropriate.

18. 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:

Individual risk assessments are reviewed within care plans as required for individual

residents. General risk assessments pertaining to the premises have been reviewed and updated. The risk register has been further developed and been updated to include the management of risks, the persons responsible and the risk ratings.

The risk management policy has been reviewed and is being updated.

Proposed Timescale: 31/08/2018

Theme: Effective Services

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

The risk management policy in the centre did not detail procedures for the unexpected absence of a resident.

19. Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

The risk management policy has been reviewed and has been updated to include detailed procedures for any unexpected absences, with a link to the Missing Persons Policy.

Proposed Timescale: 31/07/2018

Theme: Effective Services

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

The risk management policy in the centre did not detail procedures for accidental injury of residents/visitors/staff.

20. Action Required:

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

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

The risk management policy has been reviewed with guidance for staff practice in relation to procedures for accidental injury of residents/visitors/staff and a link to the safety statement.

Proposed Timescale: 31/07/2018

Theme: Effective Services

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

The risk management policy in the centre did not detail measures and actions in place to manage aggression and violence.

21. 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 has been reviewed to include the management of aggression and violence and a link to the Safety Statement.

Proposed Timescale: 31/07/2018

Theme: Effective Services

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

The risk management policy in the centre did not detail measures in place to manage self-harm.

22. 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:

The risk management policy has been reviewed to include procedures for the management of self-harm and a link to the Safety Statement.

Proposed Timescale: 31/07/2018

Theme: Effective Services

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

The inspectors found that there were not adequate arrangements in place to investigate and learn from incidents in the centre. A number of incident reports reviewed had not been appropriately followed up on, and there was no evidence of learning following these incidents.

23. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

A new template has been developed "After Incident/Accident Review Template" to ensure all incidents in the centre are reviewed and followed up as appropriate and any learning from the review is shared at staff meetings by the PIC and ADON to ensure that any actions to prevent further occurrences of similar incidents have been implemented.

The risk advisor has provided training to the PIC and ADON to enhance the use of the "After Incident/Accident Review Template"

Incident management training took place on 06/07/2018 for staff on Elm Unit. Additional sessions will be arranged.

Proposed Timescale: 31/07/2018

Theme: Effective Services

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

Fire drills were occurring regularly in the centre. However, contradictory information was contained in some of these fire drills including the time it took to evacuate. In some it was not clear how many staff and residents took part in the drills and whether all residents were safely evacuated from the centre during the drills. There was no evidence of corrective actions or learning following these drills.

24. 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:

Fire Training took place on the 20/06/2018 and the fire training officer addressed the importance of correctly documenting accurate times etc. on each fire drill and that all instances where identified issues/concerns occurred were to be clearly documented in the Additional information sheet and actioned appropriately. Learning therefore will then be evident in corresponding fire drills moving forward where previous highlighted issues should be improved or eradicated. The centre implements a horizontal progressive evacuation system where staff evacuate residents behind fire compartments away from the fire. These are areas separated from each other on the same level by walls and doors that provide 30 minutes of fire resistance and residents are moved compartment by compartment to ensure their safety until the fire service arrives. Residents are invited to participate in these drills and there is a record kept of their involvement.

Proposed Timescale: 20/06/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

A number of residents identified as requiring positive behaviour support did not have behaviour support plans in place to guide staff to support residents to manage their behaviour.

25. Action Required:

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

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

The CNS has identified the residents on both units that require assessment and support in management of responsive behaviours. To date the CNS continues to link with residents and relevant staff, work has commenced on responsive behaviours care packs for the following residents:

Lisbri – 8 residents identified

Elm – 4 residents identified

The responsive behaviour guidelines have been signed off and will be disseminated to all staff by 31/07/2018

Proposed Timescale: 31/10/2018

Theme: Safe Services

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

On reviewing incident reports in the centre, the inspectors found a number of allegations of abuse which had not been fully investigated or followed up on.

26. Action Required:

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

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

All staff have been alerted to the requirements set out in the national and local safeguarding policy for reporting of safeguarding concerns. The CNS has met with staff and has gone through registers maintained in the unit with them.

A Resident register has been developed and initiated which includes resident name, MRN, HIQA UIN, capacity to recall & convey information - task specific, capacity to manage day to day monies, ability to consent, permission to contact significant other, responsive behaviour/safeguarding concern, schedule of reassessment

A safeguarding register has been developed and identifies residents with a Safeguarding concern. For all safeguarding concerns an NF06 and preliminary screening are completed and submitted to HIQA and the Safeguarding office. This register will be reviewed and updated monthly.

All residents identified on the safeguarding register have been risk assessed and risk assessments developed and implemented. A copy of the risk is held on the residents care plan.

The Designated Officer received Designated Officer training in June 2018. 100% of staff members will have attended safeguarding training by 11/07/2018.

Changing access to the centre to assist in the greater management of access and exit from the centre will ensure that all visitors to the centre must wait to be granted access. This will minimise the risk of people not known to residents accessing the centre.

Access to the unit - A new swipe card controlled system will be commissioned by 13/07/2018. This is only available to residents and regular staff. This will ensure that all visitors must wait to be granted access to increase safety in the units.

Greater financial controls are now in place in the designated centre which reduces the potential for financial abuse.

Proposed Timescale: 31/07/2018

Theme: Safe Services

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

A number of staff described one resident's intimate care needs which were not reflective of what was documented in their intimate care plan.

27. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

With reference to the resident identified above an MDT was held on the 11/06/2018 and a specific care plan which includes intimate care was discussed and agreed upon. This is now in process and is further guided by a risk assessment implemented by the CNS on the 27/06/2018.

An urgent referral was made to the clinical psychologist following the MDT for their specialist input and support.

Proposed Timescale: 31/07/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

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

On reviewing incident reports in the centre, the inspectors found an allegation of abuse which had not been notified in line with the requirement of the regulations.

28. Action Required:

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

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

The allegation was retrospectively notified to the Authority. All incidents suspected as safeguarding are being notified to the Authority.

Proposed Timescale: 05/06/2018

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:

The inspectors found that residents had limited opportunities for education, training and employment.

29. 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:

2 residents have enrolled in a computer class in the community and 1 of the residents has commenced and attending every Tuesday for the next four weeks. The other resident has been referred to the CRC for a technology assessment.

A computer station is currently being explored in one of the units where a few residents expressed interest in learning how to use a computer.

6 residents are attending day centres in the community.

Some residents have expressed an interest in pursuing employment and referrals will be

made to the local disability services to progress possibilities of employment.

Proposed Timescale: 30/08/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The inspectors found that some residents did not have assessments or care plans in place in line with their identified needs. In addition, some residents' healthcare plans had not been updated in line with their changing needs.

A number of residents who were identified as being at risk of dehydration or malnutrition did not have appropriate assessments in place, and there was no system in place to record their food and fluid intake.

30. 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:

Multidisciplinary team meetings have now taken place for all residents. The MDT has evaluated the effectiveness of the meetings and as a result the Social Worker is taking a lead in putting a new structure in place on how future MDT review meetings will be managed. An MDT information leaflet has been developed for residents and families to assist in their understanding of the MDT process. These leaflets are available in both units.

A New schedule of MDT meetings for the rest of 2018 will be released by 01/08/2018.

A Senior Dietician took up post on the 2nd of July and a Senior SLT commenced in May 2018. The dietician will review all residents; will carry out a MUST tool audit and review relevant policies/procedures.

3 Residents where a concern about dehydration/malnutrition was raised following the inspection were reviewed by a Dietician and a detailed plan of care instigated. One resident was deemed as palliative and following discussions with the family an end-of-life plan put in place.

Proposed Timescale: 30/09/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

The inspectors found that some residents did not have access to allied health professionals, such as a dietician, in line with their assessed needs.

31. 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 senior dietician commenced on the 2nd of July 2018. - COMPLETE

Proposed Timescale: 05/07/2018

Outcome 12. Medication Management

Theme: Health and Development

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

Medicines in the centre were supplied by a central pharmacy on the campus.

32. Action Required:

Under Regulation 29 (1) you are required to: Ensure that a pharmacist of the resident's choice or a pharmacist acceptable to the resident, is as far as is practicable, made available to each resident.

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

We are reviewing the dispensing of pharmacy with a view to dispensing directly to each resident on an individual basis. Residents will be consulted as part of this review process.

Proposed Timescale: 30/08/2018

Theme: Health and Development

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

Residents' medicines were supplied from a central pharmacy and were not individually labelled for each resident. Protocols were not in place for as required medicines.

33. 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:

We are reviewing the dispensing of pharmacy with a view to dispensing directly to each resident on an individual basis. Residents will be consulted as part of this review process.

Proposed Timescale: 30/08/2018

Theme: Health and Development

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

Residents' capacity to manage their own medication forms did not detail how the decision was reached as to whether they had the capacity to manage their medicines or how the decision was reached not to manage their own medicines.

34. 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:

Every resident with capacity was spoken to by the Medical Superintendent in relation to self-medicating. All of them without exception informed the Medical Superintendent they do not wish to self-medicate and their preference is for the staff to continue dispensing medication.

These conversations have been documented in their medical notes.

The medication management committee will meet to discuss self-medication, a template for self-medication is being developed and will be added to the policy.

Proposed Timescale: 30/09/2018

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose was not available in a format which was accessible for all residents.

35. Action Required:

Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

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

All residents have been supplied with an accessible format of the Statement of Purpose.
-COMPLETE

Proposed Timescale: 30/06/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Inspectors found that the person in charge was not fully engaged in the day-to-day operational management and oversight of the centre as outlined in the body of the report.

36. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

The Person In Charge is full time supernumery but had only commenced in the post on the 23rd of April 2018. All residents are familiar to the PIC. The PIC is receiving guidance pertaining to the role from an external Disability Service.

Proposed Timescale: 31/08/2018

Theme: Leadership, Governance and Management

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

The inspectors found that the management systems in place were not ensuring that the service provided for residents was safe or appropriate to their needs as outlined in the body of this report. There were some systems put in place by the registered provider representative such as increase unannounced provider visits, meetings and additional audits. However, improvements were required in relation to providers capability and capacity in terms of the day-to-day oversight and monitoring of the centre.

37. 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 schedule of weekly monitoring by management is now in place with clearly defined roles and responsibilities for each person. A schedule of oversight meetings, management meetings, supervision sessions, incident review meetings is also in place in the designated centre with minutes available for all of the above. Reviews of the above takes place regularly.

The provider is currently working on a plan for the future of the centre which has been presented to the regulator.

Proposed Timescale: 30/09/2018

Theme: Leadership, Governance and Management

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

The inspector found that effective arrangements were not in place to support, develop and performance manage staff in the centre.

38. Action Required:

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

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

Newly devised documents for competency assessment and supervision of HCA/SCW have been developed and roll out has commenced. The Education officer met with the PIC and some staff members to explain the process and further meetings are being arranged with each supervisor and supervisee individually to provide support and clarity on its initiation. Organisational charts have been developed and are now on display in both offices showing the supervision structure. Dates of meetings are being put in place. The Nursing competency assessment and supervision documents have been developed and completed also. They will commence roll out by end of July. New Probationary Review forms have been devised and will be implemented on the appointment of any new member of staff following a two week scheduled induction period. The supervisory procedure inclusive of competency assessment will also compliment this.

The training and development officer has designed a set of staff competencies to ensure that each staff member has the knowledge and skill appropriate to their role. All supervisors are advised to complete Supervision Training which is available in HSEland.

Nursing staff and managers will complete the training module on Professional Supervision on HSEland by the 31/07/2018

Proposed Timescale: 31/07/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

The inspectors found that there were not sufficient numbers of staff with the right qualifications or skill mix of staff to meet residents' assessed needs.

39. 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:

This is being addressed by education officer a number of staff are being supported to attend courses commencing in September. The following courses are being undertaken by staff in the designated centre; MSc Rehabilitation & Disability Studies (1 Nurse), Diploma in Leadership and Quality in Healthcare(1 nurse), MSC Ageing health and wellbeing in Intellectual Disabilities(PIC). 1 HCA is commencing a Social Care course in September, 1 is going into her second year and 2 others are commencing their 3rd year of social care training. 2 additional staff members are undertaking the National Programme to Enhance Cultures of person Centeredness across the HSE. A project team is being developed which will be facilitated by the two staff members. Exploring culture within the organisation will be the first aspect to be explored.

This is a 7 month course commencing on the 19th of July 2018

The New Educational matrix will document, monitor and address education deficits moving forward in conjunction with supervisory meetings and action plans. Issues within this area will also be highlighted at the nursing administration monthly meetings and actioned appropriately.

Proposed Timescale: 30/08/2018

Theme: Responsive Workforce

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

On reviewing rosters in the centre there were a number of times when sufficient numbers of nursing staff were not available to meet residents' assessed needs.

40. Action Required:

Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

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

The nursing skill mix of the centre has been reduced as beds have been vacated and subsequently not filled. The skill mix has been reviewed in line with a change from a medical model of care to a social model of care. 7 WTE Social Care workers have been introduced into the centre from a private organisation since mid -August 2018. This includes team leaders. They are available daily to each unit in the designated centre and are supporting staff in improving resident's social care needs and person centred planning daily. Residents now have more social outings and interactions, promoting an enhanced person centred culture in the centre.

On one unit where there are a maximum of 9 long term residents with high clinical needs there are 3 qualified nurses on in the morning; 2 in the evening and 2 at night supported by healthcare assistants; household and catering staff as well as the supernumery PIC who is a CNM 2.

Proposed Timescale: 15/08/2018

Theme: Responsive Workforce

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

On reviewing rosters in the centre there were a large number of shifts covered by agency staff in the centre both on days and at night.

41. 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:

We strive not to use agency staff however due to a reduction in permanent staff it is necessary at times. All efforts are made to ensure regular agency staff are used who are familiar with the residents/service.

Efforts are underway to recruit nurse and social care workers for the service. 7 additional WTE have been introduced into the centre since mid August.

Proposed Timescale: 30/09/2018

Theme: Responsive Workforce

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

The inspectors found that staff in the centre had not completed training and refreshers in line with residents' needs as outlined in the body of this report.

42. 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:

Percentage of numbers mandatory training will vary weekly as staff dates expire. An extra session of CPR training has been scheduled for Lisbri and Elm only, on 17th July to address staff members who have recently expired. Manual Handling will also be scheduled for July for staff who also have expired and to achieve 100% compliance. One member of staff has just expired on their MAPA Training, which will be addressed when training resumes. All staff will have had Safeguarding training following a scheduled training session on the 11/07/2018.

The education Matrix highlights additional training and skills that staff members achieve, it is not mandatory training this is documented separately, but it does highlight deficits that require addressing in order to have an appropriate skill mix. It can also be evident where training is required when issues present. Identified concerns will be discussed and actioned at the individual supervisory meetings commencing next week. Fire Training in Elm Unit across all areas 100%

Lisbri is 95% of attendance for fire Lecture. Fire drill and evacuation is 100%. Fire Extinguisher training 81%

All fire training will be at 100% across both units following training sessions due to be held on 23/07/2018 and 14/08/2018.

Proposed Timescale: 14/08/2018

Theme: Responsive Workforce

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

The inspectors found that all staff in the centre were not in receipt of supervision.

43. Action Required:

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

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

Newly devised documents for competency assessment and supervision of HCA/SCW have been developed and roll out has commenced. The Education officer met with the PIC and some staff members to explain the process and further meetings are being arranged with each supervisor and supervisee individually to provide support and clarity on its initiation. Organisational charts have been developed and are now on display in both offices showing the supervision structure. Dates of meetings are being put in place. The Nursing competency assessment and supervision documents have been developed and completed also. They will commence roll out by end of July. New Probationary Review forms have been devised and will be implemented on the appointment of any new member of staff following a two week scheduled induction period.

The supervisory procedure inclusive of competency assessment will also compliment this.

The training and development officer has designed a set of staff competencies to ensure that each staff member has the knowledge and skill appropriate to their role. All supervisors are advised to complete Supervision Training which is available in HSEland.

Nursing staff and managers will complete the training module on Professional Supervision on HSEland by 31/07/2018.

Supervision has commenced in the designated centre. Records of this are available,

Proposed Timescale: 31/07/2018