

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0004649
<b>Centre county:</b>	Wexford
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Mary Gorman Coogan
<b>Lead inspector:</b>	Ide Batan
<b>Support inspector(s):</b>	Noelene Dowling
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	11
<b>Number of vacancies on the date of inspection:</b>	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 announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

From:	To:
20 October 2015 10:15	20 October 2015 18:30
21 October 2015 08:50	21 October 2015 13:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
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 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This was the second inspection of this centre by the Health Information and Quality Authority (the Authority). The centre consists of a large detached house within the community. The residents are provided with access to day services at the day centre which is approximately 1km away. The majority of residents had severe to profound intellectual disabilities. Inspectors were limited in their ability to communicate with most of the residents, and so relied on the staff to share their views of the residents' experiences. Records of assessments and judgments by other professionals were also used to offer insights on the experience of the residents.

During this inspection inspectors met with some of the residents and staff members. They reviewed the premises, observed practices and reviewed documentation related to risk management, residents' records, accident and incident reports, medication management, staff supervision records, policies and procedures and a sample of staff files. There was evidence that residents had access to members of a multidisciplinary health care team and it was obvious to inspectors during inspection that staff knew the residents and their individual preferences well. Many of the residents required a high level of assistance and monitoring due to the complexity of their individual needs. On the days of the inspection staff were seen to be treating the residents with respect and warmth, and all involved in the centre were committed to ensuring residents received the care and support they needed. However, the findings of this inspection were significantly influenced by insufficient staffing levels which ultimately impact on the quality and safety of care. Major non compliance was found in the areas of rights, dignity and consultation; safeguarding and staffing.

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

- risk management
- staffing levels were not satisfactory.
- management of complaints required review
- access to meaningful activities, day care and recreation.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Staff knew the individual preferences of residents for example, the food they preferred and their preferred choice of clothing and personal possessions. Staff were observed asking residents what they wanted and giving them choice in relation to meals, snacks and outings.

Inspectors saw that each resident was individually assessed as part of their individual activities plan in relation to their interests so that meaningful activities could be provided. Inspectors noted that many of the activities occurred in the day centre; while others occurred in the residents' houses or in the local community. For example there were activities such as swimming, bowling, art therapy and exercise programmes that involved using the soft play areas located in the house. However, inspectors saw on staffing rosters that on occasions activation was hindered by staffing levels. This is actioned under Outcome 17

In addition, a number of residents participated in their own individualised activities; often on a one to one basis with key-workers as observed in the personal plans. For example some residents regularly participated in multi-sensory programmes, hand/head massage and relaxation baths. Inspectors also noted that a number of residents regularly went home for weekends and some residents went on holiday.

There were residents meetings the last one had been conducted in September 2015. However, it was not apparent to inspectors how the majority of residents' would be represented at the residents meetings given their level of dependency and communication needs. There was an external advocate available to residents as

observed by inspectors. Residents' privacy and dignity was compromised by the use of two bedded rooms which although of a suitable size did not provide sufficient privacy. Inspectors had to walk through one double bedroom to access another residents' bedroom. The design and layout of a bathroom significantly compromised resident privacy as there were two toilets in the bathroom and the screening on the window was wholly inadequate.

There was adequate space for clothes and personal possessions in all the bedrooms. Residents were to be supported to launder their own clothes if they wished and there were adequate laundry facilities in the house. Residents' religious and spiritual needs were facilitated in so far as possible. Staff told inspectors that residents attend mass once per month in the day centre. However, staff also said that it was not always possible to take some residents out to mass on Sundays sometimes due to insufficient staffing levels.

The financial affairs of residents were being centrally managed by the organisation head office. Checks and auditing at local level of these accounts were being undertaken as confirmed by the finance manager to inspectors. Inspectors were satisfied that the process around the management of residents' finances was transparent.

Inspectors reviewed the complaint policy which contained all of the requirements of the regulations including an appeals process. The inspector reviewed a sample of complaints in the complaints log. There was a complaints policy in place. However, it was unclear how residents were assisted to understand the complaints procedure as inspectors saw that the recent complaints logged were made by staff on behalf of the residents. Inspectors saw that one complaint related to a resident being unable to meet his activation goals. Inspectors had also observed this complaint on a previous inspection in April 2015 and it still had not been resolved. The service required a review of how complainants are responded to ensuring the response is robust and appropriate to the type of complaint received.

**Judgment:**  
Non Compliant - Major

## **Outcome 02: Communication**

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

**Theme:**  
Individualised Supports and Care

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

**Findings:**  
Overall the inspectors found communication systems in place to facilitate resident's communication needs. Staff outlined to inspectors that all residents had deficits in

communication and that all residents were supported to communicate. A communication plan was in place for each resident and resident's communication difficulties were assessed and guided practice. Staff presented detailed knowledge of each individual's communication needs, and the inspectors observed this in interactions between residents and staff.

The inspectors found residents had access to speech and language therapy (SALT) and found evidence of assessment led practice in the area of communication. There was a folder available with accessible relevant information. There was also pictorial representation of pertinent information for some residents, for example, pictures of staff on duty, the food menu and areas of interest.

There were communication passports available in the event of a resident requiring care in another service. It was apparent to the inspectors that by virtue of long standing relationships staff were very familiar with the resident's communication and what it meant. Residents had access to televisions and staff were aware of their favourite television programs and music. The inspector observed that one resident had his own mobile phone.

**Judgment:**  
Compliant

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

**Theme:**  
Individualised Supports and Care

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

**Findings:**  
Residents were supported to attend a day service owned and managed by Wexford Residential Intellectual Disability Services. Activities available included swimming, bowling, art therapy and music sessions. Staff outlined and inspectors observed that transport was available to bring residents to activities.

There were no restrictions to visitors in the centre unless requested by the resident or supported by their risk assessment. Inspectors found clear evidence from review of the personal records of residents, feedback from the Authority's pre-inspection questionnaires and from speaking to staff that where available, family members were actively encouraged and involved in the lives of residents. From a sample of records reviewed, there was also evidence that family members were involved in residents' personal plan meetings and were consulted regarding any change in the residents' health or well-being.

**Judgment:**  
Compliant

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**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:**  
To comply with the Fire Regulations it is necessary that residents will relocate to a temporary location for a period of time. This premises where residents are currently living will be used to temporarily house residents from other centres managed by Wexford Residential Intellectual Disability Services while their accommodation is being upgraded. The inspectors saw that there was a system in place regarding admission to the centre. There were policies and procedures in place to guide the admissions process.

The person in charge outlined her proposed plans for residents including the supports that will be available during the transition period. Inspectors were satisfied that the transition plans were adequate for residents to move to their temporary accommodation

Written agreements were in place outlining the support, care and welfare of the residents and details of the services. This document also referenced some additional costs which could be levied for example, for holidays or furnishings and fittings. However, the detail of the additional costs were ambiguous. This was discussed with the provider nominee at the feedback meeting.

**Judgment:**  
Non Compliant - Moderate

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

**Theme:**  
Effective Services



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

No actions were required from the previous inspection.

**Findings:**

Inspectors reviewed a sample of the personal plans and saw there were inconsistencies in the completion and review of the plans. Personal plans were disjointed and inspectors found plans difficult to navigate due to the amount of unnecessary or duplicated information held in each one. It was unclear whether or not agreed time-frames in relation to achieving identified goals and objectives with named staff members responsible for pursuing objectives with residents had been met. There was not clear recording of whether the goals and objectives in the person centred plans were being met. In one instance it was recorded that staffing levels were preventing a resident from achieving his goals. Inspectors saw that staffing levels also impinged on residents attending the day centre. In a file reviewed by inspectors there were twenty one days from August 2015 when some residents could not be facilitated to access day services due to inadequate staffing levels. There was limited evidence of consultation and participation of residents or their family members in the development or reviews of care plans.

There was an activities of daily living and recreational, diversional and creativity activity assessments completed in relation to each resident. There were also proactive risk assessments and health screening tools had been completed. There was evidence of interdisciplinary team involvement in residents' care including nursing, dietician, psychiatric and General Practitioner (GP), dentist and chiropody services. There were residents' daily reports that had been completed by staff and there was also an activity profile/activity record that included details of daily activities. In particular, there was a "client profile/key things you need to know about me" was written from the residents' point of view and gave inspectors a picture of each resident.

If a resident had to attend hospital either as an emergency or as part of a planned treatment each person-centred planning folder had a form, "hospital admission pack", available which was given to the receiving hospital. There was also a protocol available for staff to follow in relation to hospital admissions. The person in charge told inspectors that it had been agreed that staff would stay with residents should they require hospitalization.

Overall, inspectors were not assured that the personal plans did not set out in a formal manner the services and supports required to enhance the quality of life of residents, to promote their independence and to realise their goals and aspirations. The plans did not adequately address:

- education, lifelong learning and employment support services, where appropriate
- development, where appropriate, of a network of personal support
- transport services for a resident

the resident's wishes in relation to where he/she want to live and with whom

- the resident's wishes or aspirations around friendships, belonging and inclusion in the community

- the involvement of family or advocate.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

The centre is a large two-storey house set in its own large grounds on the outskirts of Enniscorthy town. It was initially built in the late 1800's and was renovated in 1985 with two large extensions been added to the former home. The centre is home to 11 residents with severe and profound intellectual disabilities. Currently there are nine male and two female residents, ranging in age from 36 to 54 years.

On the previous inspection report action plan response dated April 2014 the provider nominee at that time stated that the HSE were currently tendering for assessments and surveys of all disability residential units, in the South East, with a tender completion date of 31 October 2014. These condition assessment surveys would clearly identify the overall condition and the state of compliance with the various statutory and national policy requirements. This would allow costings to be established and then added to the national mix for both capital and revenue funding to allow a realistic plan of works be agreed within an identified timeframe. The Authority did not accept this plan at that time in relation to the premises and the issues in relation to the existing centre remain the same as in April 2014.

There were four twin bedrooms rooms and three single bedrooms. There was adequate communal space for residents and a kitchen/dining area also. However, the twin rooms were not adequately designed and laid out to meet the aims and objectives of the service or the needs of residents. For example inspectors had to walk through a twin bedroom to access another residents' bedroom.

There were a sufficient number of bathrooms, showers and toilets for residents use in the centre. However, the design and layout of the showers and bathroom significantly compromised resident privacy. There were two toilets in one bathroom separated by a wall. Additional screening was also required on a window in this bathroom to protect

privacy and dignity of residents. Another bathroom which had a parker bath was extremely small and could not accommodate a hoist. These matters are actioned under Outcome 1 Residents' Right Dignity and Consultation.

Assistive equipment was required for a number of residents including hoists and specialised chairs. Records demonstrated that such equipment was serviced regularly. A maintenance log was available and issues were identified and managed promptly. Vehicles used to transport residents had evidence of road worthiness and insurance. However, there was limited storage space in the centre for the equipment and portable hoists had to be stored in a bathroom when not in use. There were satisfactory arrangements for the management of clinical and other waste.

The laundry room was inadequate in design, size and layout so that dirty and clean laundry could not effectively be segregated/managed therefore posing a risk of cross-contamination:

there was no wash-hand basin, soap or drying facility for staff to wash their hands it did not have any racking or suitable shelving for managing laundry

There was suitable car parking to the front. The external grounds were kept safe, tidy and attractive. There was a large soft-play area at the left side garden and a water feature with a paved area with seating for sitting and relaxing in. There were swings and other pieces of equipment in the garden also. There were car parking spaces available that were accessible for car/mini bus transport.

**Judgment:**

Non Compliant - Moderate

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

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

**Findings:**

Some improvements were required in the management of risk and systems for learning and review from incident and accidents although remedial systems were in the process of being implemented. There was a current health and safety statement and systems for managing environmental risks identified. The risk management policy required some amendments to ensure it included the framework for identifying and manage all of the requirements of the regulations including resident absconding and self harm. This was also required at the previous inspection.

While there was a risk register in place it was organisational as opposed to being centre-specific and this to include pertinent clinical and environmental risks for the residents. It did not satisfactorily demonstrate that pertinent risk to the residents were actually assessed and monitored which would support learning and preview.

In practice each resident had a proactive risk assessment completed which governed a number of issues such as medical physical and behavioural risks. The assessments focused on individual residents' needs, for example the potential for falls or challenging behaviours or specific medical conditions. The value of the assessments is negated by the fact that the staffing levels were consistently below par where the assessment required additional supports or supervision.

Records available demonstrated that the fire alarm and emergency lighting had been serviced annually and quarterly as required. Regular fire drills had been held in each of the houses and the outcomes noted. Fire safety management equipment including the extinguishers had been serviced quarterly and annually as required. Four staff were overdue for fire training although this was scheduled. Staff were undertaking documentary daily checks of the fire exits and alarm panels and a visitors log was maintained for evacuation purposes. Some but not all residents had a detailed personal evacuation plan in an easily accessible location and staff were familiar with these plans. However there was no adequate evacuation plan for one resident who would require specific support with evacuation. There were personal alarms for staff should they be required. Infection control procedures were satisfactory.

From a review of the accident and incident records inspectors were not entirely satisfied that there was a coherent strategy for the implementation of remedial actions and learning and review from untoward events. Incidents were not consistently or satisfactorily reviewed in a timely manner. For example, there was no evidence of remedial actions or preventative actions in a number of reports viewed by inspectors.

Just prior to the inspection the provider had commenced a system where the details of all incidents were collated and reviewed at the management meetings. The data collated included timeframes and the outcome of incidents. This was only just introduced and had as yet to be implemented.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

Some improvements were required in the systems to support residents behaviour and to ensure that vulnerable resident were protected from abusive behaviours. Inspectors reviewed the policy and procedure for the safeguarding of vulnerable adults and persons with disabilities which is the revised HSE policy issued in 2014. The director of nursing was the designated officer. The person in charge had undergone training in the implementation of this policy. Inspectors were informed that two further staff were to undergo this training to a level of "train the trainer" and would then roll out the training to the staff group. Staff were able to outline the procedures and the reporting systems. The inspectors were informed that no allegations or concerns of this nature had been made since the previous inspection in March 2015. All staff were listed as having undergone Trust in Care training in 2015.

Residents had intimate care plans devised which staff were familiar with. There was a policy on the management of challenging behaviour and the residents had complex needs. The personal plans contained direction for staff on how to support, divert and if necessary intervene in episodes of challenging behaviour. From a review of four of these plans inspectors noted that they did not consistently demonstrate clarity as to the meaning of the behaviour for the particular resident. In one instance the plans advised staff to refer to a policy as opposed to a specific intervention. There was evidence of psychiatric and psychological support on a consultancy basis.

However, ongoing assessment of the residents behaviour and guidance in relation to behaviour support plans were not available to staff. Prior to the inspection the provider had engaged the services of a behavioural specialist who was undertaking training with staff. As part of this process one resident's behaviour had been reviewed via the staff group. An individualised support plan had been devised which had just been introduced to the staff group. Some of the presenting behaviours did pose risks to other residents in the destruction of property and assaults. These were not recorded in any incident reports or considered for their impact on the other resident either emotionally or in terms of safeguarding.

It was recognised that one resident's accommodation was not suitable due to the number of residents in the centre and this impacted significantly on the other residents. There was no definitive plan in place to address this issue.

The staffing levels also impacted on behaviour due to lack of implementation of crucial elements of the behaviour support plans such as access to the swing in the garden or outside activities. Restrictive practices were minimal with the primary focus being on safety for example the front door was locked to prevent a resident leaving and placing themselves at risk. In this instance this was an appropriate strategy. A number of residents were using bedrails. These were implemented for safety reasons following

assessment. There were regular and documented checks undertaken on the resident during the night or the day of they were in bed.

**Judgment:**  
Non Compliant - Major

#### **Outcome 09: Notification of Incidents**

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

**Theme:**  
Safe Services

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

**Findings:**  
A review of the accident and incident logs, resident's record and notifications forwarded to the Authority demonstrated the provider's compliance with the obligation to forward the required notifications to the Authority.

**Judgment:**  
Compliant

#### **Outcome 10. General Welfare and Development**

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

**Theme:**  
Health and Development

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

**Findings:**  
Personal plans provided detail as to the level of personal care support and also details as to personal tasks residents could support themselves with. Staff could be seen to make efforts to ensure there was social participation for residents, for example going to shopping centres or for meals out when staffing levels permitted this. Most residents attended day care services.

Assessments were completed for residents in relation to recreation, diversional and creative activity. However, the information gathered through this assessment process was limited, recommendations of meaningful and enjoyable activities were not made and therefore the assessments did not inform practice. The assessments did not identify goals for residents with respect to education, training, development or life skills. As previously outlined, facilities for occupation and development were limited to the in-house programme for many residents due to inadequate staffing levels. This is actioned under Outcome 17 Workforce.

**Judgment:**

Non Compliant - Moderate

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

The level of support which individual residents required varied as observed by inspectors. Inspectors noted that there was timely access to medical services and appropriate treatment and therapies. There were regular General Practitioner (GP) visits, annual medical reviews and staff confirmed that the GP service was timely and responsive. Residents had access to a consultant psychiatrist who attended the centre frequently. Referrals were made to specialist neurological services as required. Where treatment was recommended or prescribed by a medical practitioner, inspectors saw that this treatment was facilitated in a timely manner. Staff informed inspectors that the level of support which individual residents required varied and was documented as part of the resident personal plan. From reviewing residents personal plans and inspectors observed that residents were provided with support in relation to areas of daily living including eating and drinking, personal cleansing and dressing, toileting and oral care.

There was evidence of a range of health assessments being used within the framework of the holistic assessment including physical well-being assessments, epilepsy nursing assessment, falls assessments, people related hazard assessment, eating and drinking assessment. Inspectors noted that there was evidence of multidisciplinary involvement in residents care and welfare including dietician, speech and language therapy, dental and occupational therapist involvement. Systems for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting were in place. There were a number of short and medium health support plans to address identified healthcare needs and records of support interventions provided by the interdisciplinary team members.

Inspectors noted that residents' families and representatives were made aware of the care and support provided to resident from the healthcare team. Residents' meals were prepared in a centralized location and delivered in heated trolleys to the units. The diverse needs of the residents were addressed in the dietary supports available. There was documentary evidence of advice from dieticians and speech and language therapist available and staff were knowledgeable on the residents' dietary needs and preferences. Although access to dietician services had recently been limited there was evidence that the GP monitored this and prescribed appropriate treatment or supplements and this did not impact on the residents well being. Resident's weights were monitored regularly and more frequently if a concern was evident. Fluid intake was also monitored where this was required.

**Judgment:**  
Compliant

### **Outcome 12. Medication Management**

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

**Theme:**  
Health and Development

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

**Findings:**  
Inspectors observed that there was evidence of good practice when administering medications such as the use of "Do Not Disturb" tabards and availability of reference resources such as the Bord Altranais agus Cnáimhseachais na hÉireann medication guidelines. Nursing staff to whom inspectors spoke demonstrated an understanding of appropriate medication management and adherence to professional guidelines and regulatory requirements. Residents' medication was stored and secured in the nurses' office and the medication keys were held by the staff nurse on duty.

Staff to whom inspectors spoke outlined that the pharmacy delivered medication to each premise on a monthly basis and on arrival was checked and signed off as correct by two staff. There were no controlled drugs in use at the time of this inspection. All residents' medication administration records reviewed had photographic identification in place. There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. For residents attending the day centre their medication were brought by the nurse in locked containers and suitably stored in the medication trolley in the centre.

**Judgment:**  
Compliant



**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The statement of purpose was sent to the Authority prior to the inspection as part of the application to register as a designated centre. The statement of purpose required amendments to ensure that it was specific to the centre and not the entire service. For example the staff listing in the statement of purpose was for the entire service and was not specific to the centre.

It was also found that the statement of purpose was not available in a format that is accessible to residents. This has been a repeat finding in all other centres under the auspice of Wexford Residential Intellectual Disability services.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspectors found that there was an organisational structure in place. However improvements regarding management systems were required to ensure compliance with the Regulations and to provide assurances to the Chief Inspector that the centre was

being efficiently governed ensuring residents were being delivered a service that was safe, effective and met their needs

The inspectors found the person in charge while very experienced in intellectual disability nursing and familiar with the organisation was new to the role of person in charge of this designated centre. The systems in place regarding the effective monitoring of services provided was inconsistent as evidenced in the variance in care planning, risk management and documentation in this centre.

While the person in charge had some good auditing in place further improvement was required in this area. Audits had taken place on issues such as medication management, restraint practices, meals and nursing documentation. However, inspectors did not observe that improvements were clearly demonstrated and corrective action plans where required addressing areas requiring improvement were developed and implemented.

The person in charge outlined that if required; she was available to be contacted by staff out-of-hours and that the CNM's were also available out-of-hours on a rotational basis. Inspectors saw that reports were compiled by the CNM'S following their weekend on duty. Staff to whom inspectors spoke were clear about who to report to within the organisational line management structures in the centre. Staff also confirmed that person in charge and her team were committed and supportive managers.

The person in charge was responsible for the day to day running of the house. Inspectors saw there were formal support and supervision arrangements in place for staff which identified goals and objectives, any issues in relation to performance and training needs that staff may require. Inspectors saw that nurse manager meetings were held on a monthly basis.

The inspector saw evidence of unannounced visits that had taken place. However, specific quality indicators were not reviewed as part of the unannounced visits. Two unannounced visits had occurred in 2015, at both visits the reports indicated the staff on duty and what the residents were doing at the time of the unannounced visit. The person in charge also conducted her own visit. Inspectors were not assured that these indicators were linked to residents' well being and quality of care and were not sufficiently reviewed or detailed in the reports reviewed by the inspector. The inspector was given an annual review of the quality and safety of care on the second day of inspection. This had been completed the previous week by an external consultant. However, there was no evidence that the annual review had provided for consultation with the residents or their representatives.

**Judgment:**

Non Compliant - Moderate

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated*

*centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspectors found there to be suitable arrangements in place for the absence of the person in charge. In the event of an absence, the clinical nurse manager would assume responsibility for the management of the centre. The inspector met with the clinical nurse manager and was satisfied that she was aware of her regulatory responsibility should an absence of 28 days or more occur for the person in charge. The person in charge was aware of her responsibility to notify the Chief Inspector of any such absence.

**Judgment:**

Compliant

**Outcome 16: Use of Resources**

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**

Use of Resources

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

No actions were required from the previous inspection.

**Findings:**

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

Sufficient resources for fundamental care such as food, health care, equipment maintenance and upkeep of the premises and vehicles used are available and utilised. However, there was evidence of insufficient staff to ensure that resident's wellbeing and access to activities could be maintained on a consistent basis in accordance with the statement of purpose. This has been a repeat finding in all other centres also. This is actioned under outcome 17 Workforce.

**Judgment:**

Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

The inspectors found that improvements were required regarding the workforce to comply with the Health Act 2007 (care and support of residents in designated centres for persons (children and adults) with Disabilities) Regulations 2013. There was a centre-specific policy on recruitment and selection of staff and the person in charge was familiar with the recruitment process.

There was insufficient provision of staff to meet the needs of the residents. There was no recognised dependency tool in use to determine the dependency levels of residents. Inspectors were not assured that the staffing levels were adequate to meet the activation needs and goals of residents as observed by inspectors during inspection and in personal plans of residents. Inspectors observed that during a three week period in October, 135 nursing hours were utilised with agency nursing staff. This does not promote continuity of care for residents. Staffing levels were low at weekends and in the evening times as observed by inspectors. The person in charge said that she would often work on the floor if staff were on leave and not replaced. This had an impact on effective management systems as the person in charge is unable to fulfil her role and meet regulatory requirements as discussed under outcome 14.

One questionnaire received by the Authority also indicated that family members expressed concern about the lack of staffing levels affecting the ability of residents to go out or engage in certain activities.

During the inspection inspectors observed the person in charge and staff interacting and speaking to residents in a friendly, respectful and sensitive way. Based on talking to staff and observations by inspectors staff members were knowledgeable of residents individual needs. The inspectors spoke to staff on duty during the inspection; all staff appeared to be competent and were aware of their roles and responsibilities.

The management team demonstrated commitment to providing ongoing education and training to staff relevant to their roles and responsibilities. There was a training plan in place for 2015. There were no volunteers working in this centre at the time of inspection.

**Judgment:**  
Non Compliant - Major

**Outcome 18: Records and documentation**

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

**Theme:**  
Use of Information

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

**Findings:**

The inspectors found that most of the records required for compliance with the regulations were up to date. All of the required policies were in place and appropriate with the exception of some minor changes to the risk management policy. It was also found that the documents were numerous with much duplication. It was difficult to find the required information from the range of available documents. Inspectors were informed that there is a pilot programme being trialled in relation to personal plans and once this was complete, a new process would be rolled out to the entire service. This new programme will enable a more succinct collation and recording of information.

Adequate insurance cover was in place. There was a Residents' Guide. The inspector found that a directory of residents was maintained. However, there were some omissions which included: the telephone number of the resident's next of kin and the telephone number of the resident's GP. The inspectors found that systems were in place to ensure that medical records and other records, relating to residents and staff, were maintained in a secure manner.

**Judgment:**  
Substantially Compliant

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Ide Batan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0004649
<b>Date of Inspection:</b>	20 October 2015
<b>Date of response:</b>	07 December 2015

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

The design and layout of a bathroom significantly compromised resident privacy as there were two toilets in the bathroom and the screening on the window was wholly inadequate.

#### 1. Action Required:

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

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

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

During the fire upgrading works scheduled to commence on 4 January 2016, the design of the toilet layout will be addressed and the windows mentioned are being removed.

**Proposed Timescale:** 12/02/2016

**Theme:** Individualised Supports and Care

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

Inspectors saw on staffing rosters that on occasions activation was hindered by staffing levels.

**2. Action Required:**

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

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

1. Since 16 November 2015 existing multitask workers and staff nurses rosters have been reviewed to enhance staffing levels

2. Current panel candidates are being processed to further enhance multitask workers allocation by two each daily in order to address social care need deficits

**Proposed Timescale:** 01/03/2016

**Theme:** Individualised Supports and Care

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

There was a complaints policy in place. However, It was unclear how residents were assisted to understand the complaints procedure as inspectors saw that the recent complaints logged were made by staff on behalf of the residents.

**3. Action Required:**

Under Regulation 34 (2) (c) you are required to: Ensure that complainants are assisted to understand the complaints procedure.

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

The PIC has reviewed the documentation to ensure it is an easy read version and key



workers have commenced reviewing the document with all service users.

**Proposed Timescale:** 31/12/2015

**Theme:** Individualised Supports and Care

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

Inspectors saw that one complaint related to a resident being unable to meet his activation goals. Inspectors had also observed this complaint on a previous inspection in April 2015 and it still had not been resolved.

**4. 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:**

The difficulty was with the availability of suitable transport. The vehicle has now gone for conversion with an expected return date of 21 December 2015. All personal goals have been reviewed and updated to ensure they are achievable.

**Proposed Timescale:** 21/12/2015

#### **Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

Details of potential additional costs were not clearly outlined in the contract.

**5. 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:**

Contracts have been amended to reflect all potential additional costs.

**Proposed Timescale:** 07/12/2015

#### **Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

The effectiveness of the residents personal plans were not reviewed annually or more often as required.

**6. 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:**

Further review of our HLP's have occurred, a new system devised and roll out commenced, with active involvement of service users / their families and key workers. This piece of work is ongoing taking cognisance of the upcoming relocation due to decant requirements to facilitate fire upgrading works. All documentation will be completed for return to the centre in February 2016.

**Proposed Timescale:** 28/02/2016

**Theme:** Effective Services

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

There was limited evidence of consultation and participation of residents or their family members in the development or reviews of care plans.

**7. Action Required:**

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

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

Annual care plan review meetings have commenced and will be ongoing over the coming months due to significant changes for all service Users. A new system has been devised, roll out commenced with active involvement of service users, their families and key workers.

**Proposed Timescale:** 28/02/2016

**Theme:** Effective Services

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

It was unclear whether or not agreed time-frames in relation to achieving identified goals and objectives with named staff members responsible for pursuing objectives with residents had been met.

**8. Action Required:**

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Documentation reviewed to include dates for goal setting and reviews.

**Proposed Timescale:** 07/12/2015

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

A bathroom which had a parker bath was extremely small and was not accessible to residents that required a hoist.

**9. Action Required:**

Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

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

This bathroom is for use by the two female service users living in the centre and both are fully mobile. This bathroom will only be utilised by those residents not requiring hoist transfers.

**Proposed Timescale:** 07/12/2015

**Theme:** Effective Services

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

The twin rooms were not adequately designed and laid out to meet the aims and objectives of the service or the needs of residents. For example inspectors had to walk through a twin bedroom to access another residents' bedroom.

**10. 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:**

The design and layout of the bedroom have been assessed by estates and works are planned to address the walk through and bedroom lay out. This work will be completed during the decant period.

**Proposed Timescale: 12/02/2016**

**Theme: Effective Services**

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

The laundry room was inadequate in design, size and layout so that dirty and clean laundry could not effectively be segregated/managed therefore posing a risk of cross-contamination

**11. 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:**

Design of the laundry room has been revised and small adjustments to the working area made.

**Proposed Timescale: 12/12/2015**

**Outcome 07: Health and Safety and Risk Management**

**Theme: Effective Services**

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

Systems for learning and review from accidents and incidents required improvements.

**12. 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:**

Schedule for review of NIMS has been established and commenced at management level with learning feed back process at unit level. Active formal involvement of the quality and risk manager for the Waterford/Wexford area in the process.

**Proposed Timescale: 07/12/2015**

**Theme:** Effective Services

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

The risk register did not demonstrate consistent identification and evaluation of risk as it was not centre specific.

**13. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

1. Centre specific schedule for review of NIMS has been established and commenced at management level with learning feed back process at unit level. Active formal involvement of the Waterford/Wexford quality and risk Manager

2. Management have reviewed the HSE risk register process and a centre specific risk register will be developed

**Proposed Timescale:** 28/02/2016

**Theme:** Effective Services

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

The risk management policy did not comply with article 26 (1) entirely as it did not satisfactorily identify the procedures for the risk of residents absconding.

**14. 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:**

Risk assessment developed for dealing with absconding and incorporated into the register.

**Proposed Timescale:** 07/12/2015

**Theme:** Effective Services

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

The risk management policy did not comply with article 26 (1) entirely as it did not satisfactorily identify the procedures for the risk of self harm.

**15. 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:**

Risk assessment developed for dealing with self harm and incorporated into the register.

**Proposed Timescale:** 07/12/2015

**Theme:** Effective Services

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

A number of staff had not had updated fire training.

**16. Action Required:**

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

The two staff are now trained.

**Proposed Timescale:** 07/12/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

In some instances the physical environment, lack of interventions, and lack of staff support contributed to behaviours that challenged.

**17. Action Required:**

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

1. All staff have received training in Positive Behaviour Support
2. Additional staffing resources allocated to ensure personal social care needs are met and activation plans carried out. Currently being processed from existing panel.
3. Approval for additional support from a behaviour psychologist received, awaiting

submission from therapist.

**Proposed Timescale:** 28/02/2016

**Theme:** Safe Services

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

Ongoing assessment of the residents' behaviour and guidance in relation to behaviour support plans were not available to staff.

**18. Action Required:**

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

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

1.Approval for additional support from a behaviour psychologist received, awaiting submission from therapist.

2.Further review of our HLP's have occurred and a new system devised and roll out has commenced, with active involvement of service users / their families and key workers.

This piece of work is ongoing taking cognisance of the upcoming relocation due to decant requirements to facilitate fire upgrading works. All documentation will be completed for return to the centre in February 2016.

**Proposed Timescale:** 28/02/2016

## **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 assessments did not identify goals for residents with respect to education, training, development or life skills, and therefore did not inform practice.

**19. 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:**

The new care plan has incorporated the identification of goals where residents are supported to access opportunities to learn and develop new skills

**Proposed Timescale: 28/02/2016**

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose requires review to ensure it is centre-specific.

**20. Action Required:**

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

The statement of purpose is currently being reviewed to ensure it is fully centre specific.

**Proposed Timescale: 31/12/2015**

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

There was no evidence that the annual review had provided for consultation with the residents or their representatives.

**21. Action Required:**

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

A revised satisfaction survey document has been developed and will be used to inform the annual review going forward.

**Proposed Timescale: 07/12/2015**

**Theme:** Leadership, Governance and Management

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

The systems in place regarding the effective monitoring of services provided was inconsistent as evidenced in the variance in care planning, risk management and documentation in this centre.



**22. 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:**

- 1.Management structure and roles and responsibilities have been reviewed to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.
- 2.Unannounced visiting schedule is under review and planned for roll out.

**Proposed Timescale:** 01/02/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Inspectors were not assured that the staffing levels were adequate to meet the activation needs and goals of residents as observed by inspectors during inspection and in personal plans of residents. Inspectors observed that during a three week period in October, 135 nursing hours were utilised with agency nursing staff

**23. 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:**

- 1.Staffing review completed, current rosters were enhanced and reconfigured with additional supports at weekends and evenings.
- 2.Additional resources approved, currently being processed from local panel to implement on a pilot to then assess effectiveness in relation to meeting the activation needs and goals of residents.

**Proposed Timescale:** 28/02/2016

**Theme:** Responsive Workforce

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

A number of staff had not had updated mandatory training in fire safety.

**24. Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to

appropriate training, including refresher training, as part of a continuous professional development programme.

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

- 1.The two remaining staff have received fire training.
- 2.The CNM2 is receiving up to date MAPA training on 10 and 11 December 2015.The other staff member remains on leave and will be scheduled on return to work.

**Proposed Timescale:** 11/12/2015

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

A directory of residents was maintained. However, there were some omissions which included:

- the telephone number of the resident's next of kin
- the telephone number of the resident's GP.

**25. Action Required:**

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

Register has been amended and updated.

**Proposed Timescale:** 07/12/2015