

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002932
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Philomena Gray
Lead inspector:	Conor Brady
Support inspector(s):	Julie Pryce; Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
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 unannounced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
24 September 2015 10:30	24 September 2015 19:00
25 September 2015 10:30	25 September 2015 19:00

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

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

Summary of findings from this inspection

HIQA became significantly concerned about the safety and the quality of life for residents in St Raphael's campus, a residential service operated by St John of God Kildare Services. St Raphael's residential campus contains seven designated centres providing residential services to 137 people with intellectual disabilities.

Following the initial inspections in 2015, inspectors undertook a series of ten planned inspections to assess the progress of the provider in addressing the issues of concern which were impacting on the lives of residents.

These unannounced inspections found evidence of institutional practices, poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued a series of immediate actions, warning letters and held regulatory and escalation meetings with the provider and members of senior

management.

Due to a failure of the provider to implement effective improvements for residents, HIQA issued notices of proposal to cancel the registration of three of the centres on this campus. The provider subsequently issued HIQA with plans for the closure of one designated centre, and transitional plans to provide alternative living arrangements for a number other residents which addressed the resident's safety, welfare and quality of life.

The most recent inspections have confirmed that the provider has undertaken substantive changes in governance and management across this campus. There have been improvements in staffing, persons in charge and other management positions. While there continues to be non compliances, and further improvements are required in relation to the quality of life for residents, the provider has demonstrated that they are now taking effective action to achieve these improvements.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection report specifically relates to one designated centre on this campus. This designated centre is owned and run by St. John of God Services and is located on a large campus based setting in North Kildare. The Authority was concerned about the levels and standard of care provided in this designated centre regarding the requirements of the Health Act 2007 and the associated statutory requirements of the Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013.

This was the fourth inspection of this centre whereby residential care was provided to 18 residents and one respite bed provided rotational respite care to a further 19 residents. While inspectors found some incremental improvements in certain areas since the previous inspection, the standard of improvement was found to be substantially non compliant with the requirements of the Regulations and Standards.

Inspectors found non compliance in the majority of outcomes inspected against on this two day unannounced inspection. While some good practices were observed, inspectors were concerned that the centre continued to be operated in a manner that did not promote a good quality of life for the residents living there.

As part of the inspection, inspectors met residents, staff and management of this centre. HIQA was informed (prior to inspection) that there was a new person in charge in place and noted this was the third person in charge in a six month period. In addition, there was a new provider nominee and CEO in place since the previous inspection which was another change in governance and management.

Inspectors reviewed practices and observed the care provided to residents over a 2 day period. While inspectors observed some good areas of individual practice and some improvement since the previous inspection, the overall standard of care and quality of life of residents was found to be very poor.

The physical premises did not meet the needs of residents in terms of building design, layout and space. All parts of the centre were not found to be clean and hygienic. Residents did not have appropriate personal space, room and/or storage. Residents' bedrooms nor bathrooms were designed or equipped to meet residents' assessed needs and were not homely in design. There was a communal bathroom/toilet in place that up to 3 residents' reportedly used (at one time) whereby only curtains were pulled to protect residents' privacy and dignity.

There was a dental office in the centre that provided care to the entire campus. The waiting area for this dental office was located in very close proximity to residents' bedrooms. This was not found to be suitable in terms of these residents' privacy and dignity needs.

Staffing levels and workforce management were found to be of significant concern. For example, inspectors found insufficient staffing levels (when inspectors benchmarked actual rosters against required whole time equivalent levels), unfilled staffing vacancies/positions, high levels of staff absenteeism, over dependence on unfamiliar agency staff and inadequate governance, management and supervision of staff. Inspectors found that these issues were having a direct and continued impact on residents' quality of life.

Residents were all highlighted as having high support/dependency needs and required substantive support with mobility, personal care, activation, behavioural support and management. In addition, many residents' also had substantial health care needs. Inspectors found that residents' quality of life was poor and the service provided was very much resource led. There was an emphasis on meeting basic needs and residents' were very much 'managed collectively' as opposed to an individualised approach to care.

While inspectors found some individual staff who were clearly doing their best to care for residents the overall structures and operational delivery of care was found to be significantly below the level that is acceptable in terms of regulatory compliance.

Each area inspected against will be discussed throughout this report and in the accompanying Action Plan.

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 inspectors did not find that residents enjoyed a good standard of rights and dignity promotion. While some measures were taken since the previous inspection regarding this outcome, inspectors found a number of areas whereby residents' rights, dignity, privacy, choice and consultation were substantially compromised.

Since the previous inspection, inspectors noted that minutes of residents meetings were now kept in the centre. In addition, a new notice board was erected and highlighted the complaints procedures, designated liaison persons and provided some information regarding independent advocacy/citizens information.

However, inspectors remained concerned with a number of areas pertaining to residents rights, dignity and privacy for example;

- residents were observed sharing bedroom spaces that were not conducive to their privacy and dignity
- a communal bathroom was in use in the centre that was inappropriate and did not promote residents' privacy
- multi-occupancy bedrooms opened directly into living room/dining room areas with doors observed to be open on a number of occasions
- one resident was observed freely moving in and out of another residents bedroom and rummaging in their possessions
- a resident was observed to be dressed inappropriately before going on a social outing wearing a shoe on one foot and a sports trainer on the other foot. Staff had not taken

the time to dress this resident appropriately before supporting him to go out on the bus. When the inspector queried this matter the resident was subsequently provided with matching footwear

- resident choice was found to be limited in the evenings when all 19 residents returned to the unit. There was a greater demand on staff at this time. For example, a number of residents were observed sitting in the same area/position once arriving in from their day services and remaining in this space for the duration of the evening with little to no engagement from staff observed by inspectors
- the evening routine was observed to predominantly focus on the provision of basic needs in terms of dinner and personal care. Some staff were observed using language such as 'he's for a feed' and 'he's for a change' when residents started returning to the centre. This did not demonstrate a person centred approach to care provision
- a resident was observed in an enclosed 'soft area' and was seeking attention at one point from staff and did not receive same as staff were busy with other residents
- residents requiring support when dining were observed staring with their mouths open at fellow residents who were having their dinner. These residents were waiting their turn to be supported to eat
- staff informed the inspectors that additional evening staffing (provided since the previous inspection) were usually utilised to assist with personal care as opposed to residents activities. However, it was noted that two of the residents were observed as having a plan to go bowling on one of the evening of inspection. There were substantive failings found regarding the area of staffing. These will be discussed further under Outcome 17.

Overall inspectors were not satisfied by the levels of social stimulation, activation and engagement observed on this inspection. The above examples did not demonstrate that resident's rights, dignity and privacy needs were appropriately provided for. Residents quality of life was found to be poor in this area and this designated centre was therefore not in compliance with the requirements of the Regulations and Standards.

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):

Findings:
Inspectors found that progress had been made in the area of communication through the development of communication plans/passports and the use of 'objects of reference'

(communication tools). All of these were areas highlighted on the previous inspection. However further improvements were required in this area.

Inspectors noted that given the profile and communication abilities of many residents residing in the centre that the onus on communication in this centre required further improvement. For example, residents who did not communicate verbally were not observed as having access to any communication assistive technology/intervention.

In reviewing residents' care plans it was not clear that all residents' communication abilities had been fully assessed and/or to what extent options and communication interventions had been attempted to support residents in this area. Only a small minority of the 19 residents communicated verbally and some residents did not have any family/representative's and no residents had ever utilised external advocacy services. The area of communication was therefore viewed by inspectors as very pertinent in this centre.

In discussing this with staff it was highlighted that an electronic communication board was being considered in respect of one resident however, this was not in place on the day of inspection. Inspectors found that further assessment and supports from a communicative perspective were required to enhance communication with residents within the centre.

The inspectors observed some staff communicating with residents in a very caring and respectful manner. For example, one agency staff member was observed gently speaking to a resident and giving them a hand massage on the sofa which the resident appeared to be really enjoying. Other staff were also observed communicating kindly with residents.

However, some other staff were observed walking past residents, not engaging with residents and staff were clearly observed as not being at all familiar with some residents. For example, inspectors observed one staff member being requested to support a resident with his meal to which the staff replied 'what is his name?'. The area of unfamiliar staffing will be further discussed under Outcome 17.

Communication documents were observed hanging from the back of residents wheelchairs, which while an attempt at making staff more familiar with residents communication needs, was not deemed to protect residents personal information. In addition, a more comprehensive induction to residents communication needs was required to ensure each staff member on duty became familiar with each residents needs clearly before working with residents.

Judgment:

Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and

includes details of the services to be provided for that resident.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

There had been no new admissions to the centre since the first inspection in March 2015. However, contracts for the provision of services were not in place for any resident.

The Person in Charge informed inspectors that no resident had a contract for the provision of services as required by the Regulations. As a result it was not agreed between the provider and residents/their representatives how the residents' care, welfare and support was to be provided for along with the fees that residents were to be charged.

Judgment:

Non Compliant - Major

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:

Inspectors found some positive developments in this area for some residents since the previous inspection. However, further improvement was required across the designated centre to ensure regulatory compliance.

A new template of residents personal plans called 'My Personal Plan' was being introduced. The new person in charge stated he had reviewed and audited four out of

the 19 residents care plans since commencing as person in charge. Inspectors reviewed these plans and noted improvements in the quality of areas such as personal profiles, pen pictures, goal setting, assessment guidance and reviews. Inspectors also found evidence of the person in charge communicating findings of the auditing of these care plans to the staff team and giving direction regarding how new care plans should be formed, presented and reviewed. In addition, the inspectors noted contact with families/representatives had been made regarding planning with some residents since the previous inspection.

Some residents had updated goals in place which were appropriate to their preferences, wishes and needs. For example a resident seeking to pursue photography, buy a tablet/personal computer and improve their physical fitness. This residents plan had been discussed with family members and updated accordingly. This resident's key worker was found to have completed a lot of work with this resident since the previous inspection.

However, inspectors also reviewed other care plans that had not yet been reviewed or updated to a similar standard. For example, residents with basic annual goal setting such as 'to go out for lunch' or to 'get familiar with objects of reference' (communication tool). In addition, the inspector reviewed a number of residents' progress notes and noted while some residents social outings had increased and some residents appeared to have increased access to community settings/activities, other residents had less opportunities for such activities.

For example, some residents had it noted in their progress notes that they ate out in a restaurant, went to the cinema and went for walks. Other residents were found to have less activities/outings recorded in their progress notes. Inspectors noted other residents who had not achieved set goals such as going on a train journey and attending a musical event, which had been highlighted as objectives the previous year.

Inspectors noted that one resident had just returned from a foreign holiday on the day of inspection which was very positive observation. When discussing resident holidays with the CNM (Clinical Nurse Manager) the inspectors were informed that this resident had been supported to go on holiday by a volunteer who supported her most years. The inspectors were informed that this one resident (out of all 19 residents) was the only individual to have a holiday this year. The CNM cited resources as the reason why the residents in this centre did not go on holidays. Inspectors queried previous years holidays and were informed that while the provider did own holiday homes, it had been 'a number of years since residents had any holidays' in this centre. While positive for the one resident who did have a holiday, inspectors were concerned that the remaining 18 residents were not supported to pursue such a basic activity.

Inspectors also found that there were sometimes discrepancies in recordings of residents' activities. For example, an activity diary was maintained but to a very basic standard and the information in this diary was found to not always correlate with the respective resident's progress notes. For example, residents were highlighted as being on an 'outing' but residents progress notes did not reflect any outings/activities. This was significant in terms of resident's whereabouts being a very basic requirement in terms of professional casework recording.

Overall while some improvements had been made since the previous inspection, the inspectors found that personal plans remained inaccessible to residents and the effectiveness of all plans had not yet been appropriately reviewed. In addition, inspectors remained concerned at the pace that actual change was happening for residents.

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:

As highlighted in the first inspection (March 2015) there were considerable concerns noted in terms of the suitability of this centre regarding the location, design and layout. The layout and design was not based on the assessed needs of 19 residents with significant mobility and physical support needs. The physical premises was not found to be conducive to residents being able to mobilise independently and many rooms were not designed or accessible for the use of necessary support equipment such as hoists, support chairs and wheelchairs.

While inspectors did not look at this outcome in its entirety on this inspection, a number of issues were observed as concerning regarding the suitability of the premises.

There was some ambiguity as to the day services that was provided and featured as part of the designated centre. The Statement of Purpose outlined this area as part of the designated centre while the floor map did not identify it as part of the designated centre. This area was used during the day to provide day services to a number of the residents within the designated centre and was also used for dining in the evening time. The person in charge stated this area was currently 'in transition' as the space available to residents for dining was highlighted as insufficient on the previous inspection.

As outlined in Outcome 1, inspectors were concerned in relation to use of a communal bathroom and toilet. This issue was discussed with staff and inspectors were informed that up to three residents would/could use this bathroom/toilet at any one time. For

example, one resident in the bath while other residents used the two toilets (all in the same room). While the toilets had side walls, only curtains were in place instead of doors and this facility was not deemed acceptable nor appropriate to promote residents rights to privacy and dignity. For example, it was not deemed acceptable that a resident be supported in the bath while two other residents' were supported to use the toilet at the same time in the same room. Staff highlighted that this was the facility they had so this is what was used.

Inspectors found that multi-occupancy bedrooms were not suitable for residents needs and residents had very limited personal space, storage and privacy in their own rooms. Residents personal possessions were observed as stored in presses/lockers on corridors as there was not enough space in their rooms for all of their possessions. Multi-occupancy rooms had curtains for screening but some residents were observed playing music while other residents attempted to watch television in the same room.

Multi-occupancy rooms for up to four residents were found to be institutional by design. Rooms were not homely with hoists observed to be stored in bedrooms and many rooms were finished/designed to a very basic standard. Inspectors observed stickers all over residents furniture with their names so staff could identify where to put the laundry which came from a central laundry. This was a measure taken for staff convenience when processing clothing from the central laundry.

Some residents' bedrooms were found to be very small and given that the majority of the 19 residents were highlighted as mobilising in wheelchairs in the internal/external environment, the size of many residents rooms were in no way suitable to manoeuvre assistive equipment. Inspectors observed 3 residents' single bedrooms and all were found to be extremely small. The largest single bedroom in the centre being the room used for respite care.

One resident observed mobilising on the floor was identified by staff as being able to walk with the support of hand rails and supervision. Inspectors did not observe these hand rails in the centre for this resident.

Another resident's room was observed to be extremely bare with padded walls and no bed. Inspectors were informed that this resident slept in a support chair as 'he did not like beds' and 'was afraid of beds'. Some staff stated the padded walls were to protect the resident from hitting the walls and hurting himself. Other staff stated the resident could not reach the walls from his chair as it was put in a reclined position.

In reviewing this resident's care plans in detail, it was clear much of the information was out of date and it was not clear whether any measures had been attempted to offer alternatives regarding his sleeping arrangements (e.g., sleeping options/beds/chairs to this resident). Inspectors saw an Occupational Therapist (OT) assessment which highlighted this resident 'slept in a chair' and prescribed a specific chair. This chair was broken on the day of inspection and the resident was in another similar chair. However, there were also elements of this assessment that were not being adhered to. This will be discussed further under Outcome 8.

Another resident's room was observed to be located beside a dental clinic which offered

service to the providers entire campus. The waiting area for this clinic was located approximately 3 feet from this residents bedroom door. The bedroom door also had a letter box and viewing window (blocked with a piece of cardboard) which indicated its previous use as an office. This bedroom was also very small (7 feet x 11 feet approx). This resident had epilepsy and significant support needs in this area and inspectors formed a view that this bedroom was too small and inappropriately located in terms of this resident's needs.

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:

Management of risk within the centre was being more appropriately responded to however, the potential for risk remained high due to inaccurate records and a high number of unfamiliar agency staff. In addition, a serious infection control issue was identified by inspectors.

Serious issues of risk identified on previous inspections had been responded to. The locking away of latex gloves to protect one resident with specific behaviours was now being carried out and appropriately monitored. Manual handling within the centre had been the subject of an audit resulting in updated assessments in this area. A second manual handling audit was in the process of being completed at the time of this inspection and inspectors observed instances of safe manual handling practice. The manual handling instructor was seen in the centre on the first day of inspection.

Inspectors reviewed an incident whereby a staff member was injured when assisting a resident with personal care. In reviewing this bathroom with staff it was clear that this incident was largely based on the inability of staff to move/manoeuvre appropriately to support residents due to premises layout. This matter had been addressed under Outcome 6.

An accidents and incidents log was reviewed by inspectors and it was noted that issues which required attention were being reassessed. A risk register was in place however, it did not contain all risks that had been identified within the centre. For example it did not include one resident who was described by the CNM2 on duty as being at serious risk of aspiration. In addition some risks listed under one resident in fact related to a different

resident. For example, resident's information regarding behaviours that challenge was listed under the incorrect residents risk assessment.

Inspectors were informed that risk assessment, along with accidents and incidents in the centre were now discussed at staff meeting on a fortnightly basis. However, due to over reliance on unfamiliar agency staff within this centre this posed some difficulties. These will be discussed in greater detail under Outcome 17. Consequently inspectors had concerns regarding the capacity of such agency staff to fully comprehend the risks associated with residents, many of whom who were high dependency and had very complex needs.

For example, inspectors observed new staff being handed residents food and nutrition (consistency and modification) care plan documentation, as they were already in the process of assisting residents with their meals. This did not offer assurance that these new staff were appropriately inducted and fully aware of residents care and support needs prior to assisting them with same. This was a particular concern as a number of residents in this centre were highlighted as a high risk of aspirating and had individual requirements pertaining to specified consistencies of both food and fluids. Inspectors found a recent incident whereby a resident had been given fluids at the incorrect consistency which the person in charge was following up at the time of inspection as a 'near miss'.

Inspectors were informed that a process was in place to induct agency staff into the centre. An inspector observed one agency staff member being inducted and noted that broad issues such as fire and residents with epilepsy were discussed, the agency staff member was directed to the location of certain documents such as personal evacuation plans for review. The risk register was also provided to agency staff during this induction but as highlighted above this document was incomplete and inaccurate which posed a risk to residents.

Permanent staff expressed concerns regarding the supervision of agency staff, the length of time induction was taking and that the induction process was not sufficient to ensure that such staff were fully aware of risks within the centre. Inspectors were also very concerned regarding the number of inductions that some agency staff were receiving within a short space of time. For example one agency staff member stated to an inspector that she had received inductions to four of the provider's services, including this centre, within the previous 24 hour period. This staff member was found not to be appropriately knowledgeable regarding the evacuation procedures of the designated centre which the inspector requested be immediately addressed by the staff member.

Inspectors found that unfamiliar staff was not a feature on the risk register nor was this issue appropriately risk assessed despite the fact that 5 residents' behaviours were highlighted to be triggered negatively by unfamiliar staff.

Inspectors found that personal protective equipment was available in the centre and cleaning staff were seen on both days of inspection. A new local procedure on the safe handling and disposal of healthcare risk waste had been recently introduced and at the time of inspection had been signed by 19 staff members. However, on day one of inspection a clinical waste bin was found to be overflowing in a bathroom/toilet area. In

addition, a 'soft area' was inspected and the cushions and soft mat's were found to be stained and requiring a deep cleaning.

On day two of inspection a specialised chair belonging to a resident (in which this resident also slept) was present in one of the day/dining rooms. The chair was examined by an inspector and was observed to be dirty, with stains, food, dirt, hair and faecal matter stains on the seat. A review of cleaning records indicated that the chair had been signed off as being cleaned by two separate members of staff the previous evening. The inspector formed a view that given the amount of stains and dirt observed the chair in did not indicate it had been subject to any form of appropriate cleaning. It was not only concerning that this chair was found as it was but it was also located in close proximity to a dining table where residents ate everyday. Inspectors were therefore not satisfied with infection control practices in this regard.

Inspectors found a fire drill had been carried out in the centre since the previous inspection and internal staff checks were being carried out. However, as highlighted above all staff were not fully familiar with evacuation procedures, the issue of staff training will be discussed further under Outcome 17.

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:

Inspectors were not satisfied with safeguarding arrangements in place and found areas that were highlighted on the previous inspection had not been satisfactorily addressed. In addition, inspectors were not satisfied that all residents requiring behavioural support plans had same in place and noted restrictive practices in operation that were not prescribed.

A safeguarding policy was in place and a system for reporting safeguarding concerns was present in the designated centre.

Inspectors found that there were 2 safeguarding referrals noted to the designated liaison person (DLP) regarding an unwitnessed fall and an instance of suspected peer/peer abuse. As highlighted in Outcome 7 inspectors were concerned that the volume and frequency of unfamiliar agency staff was a risk in this centre. Inspectors reviewed a sample of staff files of agency workers and found no evidence that all such staff had received appropriate training in the safeguarding and protection of vulnerable residents. This was an area that the provider stated would be addressed following the previous inspection of this centre. This was not found to have been carried out.

In addition, inspectors spoke to agency staff members who could not describe the different forms of abuse, while another staff stated that they had not undergone any safeguarding training. In light of the volume of agency staff working in this centre (84 different agency staff in under 3 months) and the centre's reliance on such staff, an immediate action was issued under Outcome 17 concerning the supervision of these staff members on duty who did not have any evidence of appropriate training in both protecting vulnerable adults and fire safety. Training lists provided for permanent staff members indicated that these staff had received safeguarding training.

Inspectors were not satisfied with arrangements in place regarding behavioural management and positive behavioural support within this centre. A positive behavioural support plan for one resident contained guidance that pertained to the residents previous living environment and not the designated centre the resident was actually living in. The staff guidance in this plan was found to be therefore out of date and not reflective of the residents current needs. It was also noted that this behavioural support plan had not been signed off by a psychologist or appropriate clinician.

Inspectors noted a restrictive practice in operation that was not prescribed whereby a resident was strapped into a chair, this resident's assessment prescribed that this lap-strap be only utilised for safety reasons when the resident was mobilising. Inspectors observed this resident return from day services and be strapped into a chair for the duration of the evening.

In addition, inspectors found that there were two residents who were able to mobilise in their wheelchairs, by using their feet to propel themselves. However, each of these residents was removed from their wheelchair when they returned to the designated centre in the evenings. The explanation given to inspectors for this was to manage difficult behaviour and falls for one resident. The explanation for the other was to prevent the ingestion of inedible material, although there was no documentation in his records to support this. The removal of mobility for these two residents had not been seen as a restriction and was not assessed or documented as such.

For one of these residents there was a manual handling assessment which recommended the use of the wheelchair for mobilising, and a falls risk assessment that did not refer to managing falls by restricting mobility. In addition, a proactive strategy for this resident stated that he 'liked to move independently around the unit in his manual wheelchair' and the reactive strategy identified a trigger to challenging behaviour as being his inability 'to leave or escape a situation or activity'.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

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

Findings:

There was an annual health assessment and medical review for each resident, and evidence that this system had resulted in the detection of healthcare issues for residents. For example, the diagnosis of diabetes for one resident followed from the health assessment.

There was evidence of some appropriate management of healthcare needs for example in the management of epilepsy, diabetes and skin integrity, and in the management of injection sites for residents on daily injections. For example, there was evidence of appropriate treatment and practices relating to a resident with a history of skin integrity issues. Staff knowledge of the treatment plan was detailed, and appropriate referrals had been made.

However, not all of the information given by staff was documented appropriately. Some documentation, for example the nutrition plan for one resident was undated, and as this plan required the review by the dietician it was unclear as to whether an appropriate referral had been made in this case. Some of the healthcare goals were vague and therefore not measurable, for example, 'to gain weight'.

There were inconsistencies in the implementation of food and nutrition plans for residents. Staff assisting one resident were seen to follow the plan of care and the recommendations of the speech and language therapist, and it was clear from observation of the process that the resident was used to this way of being assisted, However, the recommendations of the speech and language therapist were not implemented for another resident, for example the guidance was that an assistive cup should be used together with slow sips. Neither recommendation was observed to be implemented.

Inspectors were concerned about the quality of the mealtime experience. In one of the dining areas when the evening meal was being served a resident who was visually impaired was left waiting for his meal long after the other residents had been served, despite the fact that he did not need assistance. In another dining area all residents

were seated at the dining table, but because all needed some level of assistance, half of these residents sat watching the others eat their meals until there was someone available to assist them. A resident was observed with his mouth open gesturing for his food.

In a third location a resident who could not take food orally sat in the dining area a short distance from the table whilst the others were served. The explanation for this was that he liked to assist however, he was observed later to offer this assistance and the offer was refused. The issue of residents waiting in this manner was identified at the previous inspection and had not been addressed.

There was still no evidence of residents being supported to partake in food preparation, despite this being an agreed action following the previous inspection. Inspectors were concerned as to how this could be managed given the layout of the building and the narrow kitchen areas. However, staff described some improvements in this area since the previous inspection, for example, there was now a budget for shopping for snacks and mealtime options.

However, inspectors were still concerned about the offering of choice of meals to residents. There were two options prepared by the main kitchen of the campus each evening and sent to the centre. However, on many occasions one of these options was not suitable for residents who required a modified diet. Staff explained that options were available in the fridge, for example microwave ready meals, but inspectors did not observe any choice being offered.

The designated centre had conducted an audit of mealtimes in August 2015, and had identified required actions. Two of the actions were that staff were to avoid approaching residents from behind and to avoid moving residents without communicating with them. Inspectors observed both of these practices during the course of mealtimes. In addition, an identified action was that the serving trolley should be turned so that staff did not have their backs to residents however, this had not been implemented.

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:

Inspectors reviewed a sample of prescription and administration records and noted that some improvements were required. For example, not all prescriptions were individually signed. In addition there was a prescription in the record of one resident which was not signed, and a discontinued medication that had been struck out but not signed. This was rectified during the course of the inspection before the next administration of the medication.

Whilst the external pharmacy company had conducted an audit, there had been no internal audits of practice conducted, and inspectors were concerned that this was the reason that errors had not been detected.

A secure fridge was provided for medications that required specific temperature control, and the temperature of this fridge was maintained within appropriate limits, and recorded daily.

Appropriate practices were in place in relation to the ordering, administration and storing of medications for the most part. For example, a signature bank of all staff administering medications was maintained. However, the administration of an 'as required' (PRN) psychotropic medication in relation to challenging behaviour reviewed by the inspectors did not include appropriate information. There was no record of the behaviour which had occurred, either in a behaviour incident form as required by the centre's policy, or by any record in the resident's notes.

The management of oxygen was reviewed and there was evidence of appropriate practices in relation to prescriptions and protocols and in the safe storage of oxygen. However, whilst checks were maintained of oxygen levels in cylinders in the centre, there was portable oxygen in the centre's bus for use in an emergency, and the levels of this were not checked.

There was evidence of appropriate reviewing of medications, for example, medications for the management of epilepsy for one resident were causing drowsiness. These medications had been repeatedly reviewed, and an alternative treatment had been identified and arranged. In addition, the permanent staff nurses engaged by the inspectors were knowledgeable about the medications for each individual resident, including doses, associated conditions and treatment plans.

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:

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

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

Findings:

Inspectors remained concerned with the governance and management of this designated centre. Inspectors noted a third person in charge in a six month period with this person in charge stating he would not be remaining in this centre as another new person was again being recruited. Inspectors found that this inconsistency and lack of continuity from a governance perspective (since commencement) has been a significant barrier to compliance with the Regulations in this designated centre. This is evidenced by the centres continued non compliance with the Regulations over the three inspections to date.

The person in charge was responsible for the governance, operational management and administration of three designated centres at the time of inspection. Inspectors found that due to the levels of non compliance observed in this centre that a person in charge for 3 designated centres on this campus was not a suitable and appropriate management approach by the provider.

The person in charge had been in place since the 20 July 2015 and inspectors noted incremental progress in some areas since the previous inspection. However there was still further development required regarding effective oversight within the centre. For example, when discussing the person in charges levels of oversight and auditing it was apparent that at the time of inspection only a small percentage of residents personal plans and care plans had been reviewed by the person in charge. This has been discussed under Outcome 5. In addition, inspectors found the person in charge had liaised with the Human Resource Department regarding unfilled staff vacancies (6) and the high rates of absenteeism prevalent in the centre but there was not yet tangible solutions highlighted to address these on-going issues.

In terms of the management and oversight of health, safety and risk management and safeguarding and safety, the person in charge had completed a risk register however there were shortcomings found in this area. This has been outlined under Outcome 7. When asked whether all staff were aware of the main risks prevalent within the designated centre the person in charge stated that he was 'not sure' if all staff were aware of the content of the risk register as it had only been formulated in August 2015. This concerned the inspectors and as outlined in Outcome 17, this concern was further compounded by the fact that there were more unfamiliar agency staff on duty than regular/permanent staff on the first day of this inspection.

In terms of safeguarding oversight and auditing the person in charge stated he had followed up one instance deemed a safeguarding concern since the previous inspection and stated he had not yet conducted any auditing specific to safeguarding within the designated centre.

Inspectors noted an audit of the mealtime experience had taken place by the catering department since the previous inspection. Some positive changes had occurred in this area, however negative outcomes for residents were still clearly visible. This has been discussed under Outcome 11.

As highlighted in the previous inspection, while a quality enhancement plan was in place regarding this centre. Inspectors remained concerned that while this plan set targets and timelines for the provider to move towards compliance, this was not deemed to be effectively and efficiently improving the quality of life of residents. For example, there was not evidence of annual reviews of quality and safety in terms of care provided. In addition, arrangements in place regarding staff supervision and staff training staff were again found to be insufficient. Undertakings were made by the provider following the previous inspections that these areas would be addressed. This was not found to be completed to a satisfactory standard.

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:
There was an insufficient number of staff to provide for the needs of residents, while the continuity of care and support was also an area for serious concern. Significant training gaps were identified during inspection which resulted in an immediate action being issued to the provider regarding the supervision of staff due to the absence of any evidence of mandatory training being provided and/or completed.

Prior to this inspection the provider had stated that a full complement of staff was employed within the centre. However during inspection it was disclosed to inspectors that the centre had a number of vacancies in addition to a very high absenteeism rate. In reviewing the staffing rosters it was clear that staffing compliments were not maintained in this centre in accordance with the statement of purpose. For example an occasion was seen whereby staffing levels fell to eight staff on duty as opposed to the full complement of eleven staff that was required. The person in charge highlighted on-

going difficulty whereby he did not have enough staff on duty in this centre.

On the day of inspection inspectors were informed that one staff member did not show up for work and no replacement staff was provided. On both days of this inspection staff members were observed working beyond their rostered hours to care for residents. For example, one staff member remained in the unit working for over 6 hours after her rostered shift finished on the first day of inspection. Another staff member had been requested to stay on duty after her rostered shift finished and was observed supporting residents to eat their dinner on day two of inspection. Inspectors were concerned that at no point on this inspection was the centre staffed as outlined on the roster in terms of numbers/personnel. This concern was further compounded by a lack of staff to respond to the individual and collective needs of the 19 residents in this centre.

Although the centre had some committed and passionate core staff, the overall lack of staff was having a negative impact on residents. For example on one occasion a resident was observed hitting his head three times while mobilising around the centre with no response/observation from staff. This was attributed to an inability to provide this resident with 1:1 supervision as a direct result of low staffing levels.

Staff also expressed concerns that the time spent inducting agency staff was taking away from the care that permanent staff could provide. A staff nurse stated they are inducting new people on almost every shift which is having an impact of care delivery. As highlighted under Outcome 7 inspectors were concerned that an agency staff member stated she had received 4 inductions in 4 different St. John of God Services in a 24 hour period. Inspectors were not satisfied that all staff were being appropriately supervised and performance managed in this designated centre. The person in charge highlighted that absenteeism and vacant staff positions as a serious concern in this centre.

As a result of the high number of permanent staff vacancies there was an over reliance on agency staff in this centre. In the period prior to this inspection (29/6/15 - 24/9/15) a total of 84 agency staff were employed within the centre. Many of these agency staff members were unfamiliar to residents. Despite this, unfamiliar staff was highlighted as a negative behavioural trigger for 5 of the 19 residents in this centre.

Inspectors found there was no regular panel of agency/relief staff for the centre to choose from. Inspectors were informed that a panel was 'in the process' of being compiled but this panel would be used in the first instance to cover the existing vacancies in the centre's allocated staff compliment. Recent staff meetings had highlighted the rise in unfamiliar staff as a concern and cited the need for familiar agency staff.

As highlighted under Outcome 8 evidence gathered during inspection showed that not all agency staff members had received safeguarding training. Given the high number of agency staff that was utilised in the centre an immediate action was issued to the provider to ensure that such staff members were appropriately supervised. Prior to the conclusion of this inspection the CEO of St. John of God Services, gave written assurance on this issue which is included as part of the action plan at the end of this report.

Other training gaps were also identified during the course of inspection. Certain residents were assessed as requiring care and assistance from staff members who were trained in Management of Actual or Potential Aggression (MAPA). A review of staff training records for permanent staff showed that not all staff had received such training. In addition the review of agency files highlighted gaps in terms of fire and manual handling training.

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):

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

Findings:

Regarding records and documentation while some improvements were noted in some areas such as residents food and fluid intake since the previous inspection, further improvement was required to ensure regulatory compliance.

As highlighted in Outcome 5 and Outcome 7 inspectors noted some discrepancies in the accuracy of some documentation reviewed. For example, in the unit activity diary and residents progress notes as to where residents were on specific dates and the activities they partook in. In addition, inaccuracies were also noted in residents information recorded in the centre risk register.

Inspectors reviewed operating policies and procedures within the centre and found that some policies were not reviewed and updated. A review of the centre's policies highlighted some policies, such as the policy on the provision of personal intimate care, which had not been reviewed within a three year interval as required by the Regulations. In addition the safeguarding policy available in the centre was dated October 2013 and was described as an interim policy. It had not been updated to reflect recent changes in national policy in this area. Inspectors noted that while policies were

drafted and some new draft local operational policies were in place since the previous inspection, these were not implemented in practice. For example, a local operational policy on privacy and dignity.

A directory of residents was available in the centre however, it did not include all residents. For example 18 respite residents were not featured in the directory. A residents' guide was also in place however it did not contain sufficient detail, for example the arrangements for visitors to the centre. The Person in Charge informed inspectors that the residents' guide was being reviewed at the time of inspection.

All other documents requested by inspectors were made available during the course of inspection.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Conor Brady
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 St John of God Community Services Limited
Centre ID:	OSV-0002932
Date of Inspection:	24 September 2015
Date of response:	28 October 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:

Residents were not observed to have 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:

1. Weekly residents' meetings have commenced with an agreed agenda to ensure that each resident has the opportunity to exercise choice and control in his or her daily life.
2. The Person in Charge will supervise staff regarding offering the choices and control and giving residents opportunities to exercise choice and control in their lives.
3. Develop weekly schedules with resident of preferred activities of the residents' choice.
4. The daily shift leader under the supervision of the Person in Charge will ensure that these activities are completed.
5. Practice development workshops focusing on POMS/ Person Centred Planning will be scheduled for staff.

Proposed Timescale:

1. 24/5/2015
2. 2/11/2015
3. 16/11/2015
4. 16/11/2015
5. 11/12/2015

Proposed Timescale: 11/12/2015

Theme: Individualised Supports and Care

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

Each resident's privacy and dignity was not found to be 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.

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:

1. Staff will be re-inducted to local operational procedure (LOP) on Privacy and Dignity.
2. The Agency induction sheet will be reviewed to ensure all agency staff will receive induction on local operational procedure on Privacy and Dignity prior to commencement of shift.
3. The Person in Charge and Clinical Nurse Managers will supervise staff and ensure that the privacy and dignity in relation to Residents' personal space, communications, relationships, intimate care, consultations and personal information is respected.
4. A review of the premises has been carried out with the registered provider, PPIM and

the architect; a renovation action plan is being devised.

5. Residents will be provided with their own bedroom and adequate storage space to store and maintain his or her clothes, personal property and possessions.

Proposed Timescale:

1. 30/11/2015
2. 16/11/2015
3. 09/11/2015
4. 13/11/2015
5. 30/03/2016

Proposed Timescale: 30/11/2015

Theme: Individualised Supports and Care

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

This centre was not found to operated in a manner that respected the rights and disabilities prevalent in this designated centre.

3. Action Required:

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

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

1. The Person in Charge will take responsibility for ensuring that staff are re-inducted to local operational procedure (LOP) on Privacy and Dignity.
2. The agency induction sheet will be reviewed to ensure all agency staff will receive induction on local operational procedure on Privacy and Dignity prior to commencement of shift.
3. Staff will be appropriately supervised and supported regarding use of language relative to the provision of care.
4. Staff will receive practice development workshops on rights based on the UN Convention on the Rights of Persons with Disabilities.

Proposed Timescale:

1. 30/11/2015
2. 16/11/2015
3. 09/11/2015
4. 30/12/2015

Proposed Timescale: 30/12/2015

Theme: Individualised Supports and Care

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

Residents did not have adequate space to store and maintain his or her clothes and personal property and possessions within their rooms and personal environment.

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:

1. A review of the premises has been carried out with the registered provider, PPIM and the architect; a renovation action plan has been devised.
2. Residents will be provided with their own bedroom and adequate storage space to store and maintain his or her clothes, personal property and possessions.

Proposed Timescale:

1. 13/11/2015
2. 30/03/2016

Proposed Timescale: 13/11/2015

Theme: Individualised Supports and Care

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

Each resident was not found to be provided with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

5. Action Required:

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

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

1. Staff member responsible for dressing the resident inappropriately was met with and the observation was highlighted as a performance issue.
2. Person in Charge shall ensure there is a person centred plan in place for each resident which identifies their support needs using the Personal Outcome Measures information gathering tool.
3. Each Person Centred Plan will be reviewed for effectiveness on three quarterly and

an annual review.

Proposed Timescale:

1. 28/09/2015
2. 30/11/2015
3. 30/12/2015 moving forward.

Proposed Timescale: 30/12/2015

Theme: Individualised Supports and Care

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

All residents were not found to have equal opportunities to pursue interests and activities in accordance with their needs.

6. 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. The person in charge will ensure Residents have equals opportunities to pursue interest and activities in accordance with their person centred plan and are supported to participate in activities in accordance with their person centred plan.
2. Each Person Centred Plan will be reviewed for effectiveness on three quarterly and an annual review.
3. The Person in Charge will review the activities to ensure residents are receiving positive outcomes from these activities.

1. 30/11/2015
2. 30/12/2015
3. 30/11/2015

Proposed Timescale: 30/12/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

No residents were observed as having been assessed or provided with assistive

communication technology.

7. Action Required:

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

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

1. All residents' communication abilities will be fully assessed and if required residents will be provided with assistive communication technology.
2. One Resident is using assistive technology (Big Mack).
3. There is a Powerlink device in place for all residents to trial. The Powerlink supports people to understand cause-and-effect link and promotes the control over certain parts of their lives.

Proposed Timescale:

1. 28/02/2016
2. 25/09/2015
3. 27/10/2015

Proposed Timescale: 27/10/2015

Theme: Individualised Supports and Care

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

All residents were not observed to be responded to and communicated with in accordance with their needs and wishes.

8. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

1. The communication needs of residents are discussed with the staff team at fortnightly staff meeting.
2. The Person in Charge will ensure that staff are appropriately supervised and guided to use appropriate communication with the residents including their specific communication systems.
3. Communication training in the areas of objects of reference, visual schedules, choice making and total communication is being provided to staff by SLT.
4. Person in Charge will ensure that each resident has a communication passport as required and that all staff working with the residents will be familiar with residents' communication needs.

Proposed Timescale:

1. 28/9/2015
2. 09/11/2015
3. 30/11/2015
4. 30/11/2015

Proposed Timescale: 30/11/2015

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:

There were no agreements regarding the provision of services in place for any resident.

9. 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:

1. Supports agreements will be developed with each resident in DC 1; detailing supports services and charges for each resident, in line with schedule 4.

Proposed Timescale: 31/12/2015

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:

All personal plans were not in an accessible format for residents.

10. 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:

1. An accessible MPP has been developed and is under review by the Speech & Language Therapy department (SALT).
2. Each Resident will have an accessible MPP available to them
3. Practice development workshops will be scheduled for staff on the Role of the Key

worker.

Proposed Timescale:

1. 31/11/2015
2. 15/01/2016
3. 31/12/2015

Proposed Timescale: 15/01/2016

Theme: Effective Services

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

All residents personal plans had not yet been audited in terms of their effectiveness.

11. 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:

1. The Person in Charge will develop an audit schedule for the auditing of personal plans.
2. The Person in Charge will ensure that findings of the personal plan audits will be communicated to the relevant members of staff.
3. All personal plans will have one annual review; which will include an information gather and planning meeting, and three quarterly reviews.
4. A schedule will be put in place to review personal plans at local staff meetings to ensure target dates for review of plans are maintained.
5. Details of review, progress and any changes, new actions will be documented and maintained in residents MPP file.
6. Personal Plan reviews will be an agenda item at local staff meetings;

Proposed Timescale:

1. 09/09/2015
2. 30/11/2015
3. 30/12/2015 moving forward
4. 30/11/2015
5. 30/11/2015
6. 30/11/2015

Proposed Timescale: 30/12/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The premises did not meet the assessed needs of all residents.

12. 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:

1. A review of premises is being carried out with the registered provider, PPIM and architect; a renovation action plan is being devised.
2. Residents will be provided with their own bedroom and adequate storage space to store and maintain his or her clothes, personal property and possessions
3. Respite services have ceased in DC1 and the bedroom will be decorated with regard to the needs and preferences of the resident that will occupy the bedroom.
4. The Resident identified in the report in respect of the use of hand rails will be referred to OT for an assessed.
5. The resident identified in the report as having an alternative chair to the OT assessment has been provided with the prescribed chair.
6. The dental clinic has ceased operating and residents are accessing community dental services. This former dental clinic is currently being renovated to provide bedroom for one resident.

Proposed Timescale:

1. 13/11/2015
2. 30/03/2015
3. 16/11/2015
4. 30/11/2015
5. 30/11/2015
6. 16/11/2015

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

There was not full and accessible assistive technology available to all residents. For example, resident's mobility needs.

13. Action Required:

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities

and independence of residents.

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

1. Through Person Centred Planning process the needs of residents in relation to accessible and assistive technology will be identified with support from Occupational Therapist as required.
2. Identified equipment where required will be installed within the DC.

Proposed Timescale:

1. 30/11/2015
2. 30/12/2015

Proposed Timescale: 30/12/2015

Theme: Effective Services

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

All parts of the premises were not fully accessible to all residents.

14. 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:

1. A review of premises has been carried out with the registered provider, PPIM and the architect; a renovation action plan is being devised which includes alterations to ensure accessibility for residents.
2. As an interim measure pending the design and build of smaller purpose built accommodation, suitable to the needs of residents within a 3 -5 year time frame Residents will relocate to DC 8.

Proposed Timescale:

1. 13/11/2015
2. 30/09/2016

Proposed Timescale: 13/11/2015

Theme: Effective Services

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

All requirements of Schedule 6 of the Regulations were not provided for in this

designated centre.

15. 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:

1. A development committee has been established to identify suitable/alternative accommodation.
2. A review of the number of residents in DC1 has been carried out. The plan is to have no more than twelve residents in DC 1 in the short term. This will ensure single occupancy bedrooms.
3. Renovation and re-decoration as well as a review of bathroom facilities and communal spaces is being carried out and actions identified to ensure the requirements of schedule 6 are met.

Proposed Timescale:

1. 30/06/2015 Commenced and on-going
2. 20/10/2015
3. 30/03/2016

Proposed Timescale: 20/10/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

There were not appropriate systems in place in the designated centre for the assessment, management and on-going review of risk. All risks were not identified and assessed appropriately and some risk documentation was found to be inaccurate.

16. 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. The risk assessment in relation to the resident at risk of aspiration has been completed identifying emergency response.
2. Review of risk assessments will be carried out and incorrect risk assessments will be rectified. Risk assessments will be reviewed quarterly or sooner if required.
3. The risks associated with unfamiliar staff supporting the residents will be assessed and documented appropriately on the risk register.
4. The risk register will be reviewed and updated as required.
5. Risk assessment practice development training is scheduled and will be provided for

staff.

6. The PIC will review all incidents and accidents daily and weekly, identifying causal factors, analyse themes and put additional control measures in place to reduce the likelihood of reoccurrence as required.

Proposed Timescale:

1. 28/11/2015
2. 30/11/2015
3. 30/11/2015
4. 30/10/2015
5. 30/10/2015
6. 09/11/2015

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

There were not appropriate clean and hygienic standards maintained in the centre to prevent against infection.

17. Action Required:

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

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

1. The specialised chair has been cleaned to appropriate standard.
2. The cushions and soft mats have been deep cleaned.
3. CNM2 has met the staff responsible for cleaning of the specialised chair and the expected standard of cleaning was reinforced.
4. A cleaning schedule for the cushions and the soft mats is in place.
5. The clinical waste bin was emptied on the day of the inspection.
6. The Person in Charge will ensure that staff are supervised and that appropriate monitoring of the hygienic standards takes place.
7. The Infection control policy will be disseminated to all staff in DC 1 for staff to read and sign.

Proposed Timescale:

1. 25/9/2015
2. 28/10/2015
3. 30/9/2015
4. 28/10/2015

- 5. 25/9/2015
- 6. 16/11/2015
- 7. 30/11/2015

Proposed Timescale: 30/11/2015

Theme: Effective Services

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

All staff (agency) were not appropriately familiar with the evacuation procedures in the event of a fire.

18. 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:

1. Comprehensive induction to evacuation procedures in the Designated Centre is provided to all agency staff.
2. Staff supervision and monitoring will be improved – Person in Charge will be based in the Designated Centre and solely responsible for the operation of one DC.
3. Agency staff can no longer present to work in the Designated Centre unless they have receive training in all mandatory areas. Request for training records are made to the agency on booking of staff.
4. Person in Charge and or Clinical Nurse Manger provide agency and service staff with a thorough induction to the Designated Centre.

Proposed Timescale:

1. 25/09/2015
2. 02/11/2015
3. 26/10/2015
4. 02/11/2015

Proposed Timescale: 02/11/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Physical restraint was observed that was not in line with residents assessments.

19. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

1. Physical restriction that was not in line with resident's assessment was removed.
2. The use of un-prescribed restrictions was discussed with staff team.
3. The Person in Charge will ensure staff are supervised and monitored in relation to the use of restraints.
4. Practice development workshops with regard to pro-active and reactive strategies will be provided for staff.

Proposed Timescale:

1. 25/09/2015
2. 30/09/2015
3. 16/11/2015
4. 30/12/2015

Proposed Timescale: 30/12/2015

Theme: Safe Services

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

All agency staff did not demonstrate appropriate knowledge of the different forms of abuse and had no evidence that they had undergone safeguarding training.

20. Action Required:

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

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

1. Agency staff can no longer present to work in the Designated Centre unless they have receive training in all mandatory areas. Request for training records are made to the agency on booking of staff.
2. Training was made available to Agency staff on the weekend of 09/10/2015
3. The Person in Charge will discuss the safeguarding of residents and the prevention, detection and response to abuse during team minutes and regularly during morning handover and on induction of agency staff

Proposed Timescale:

1. 09/10/2015
2. 30/11/2015
3. 02/11/2015

Proposed Timescale: 30/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There was insufficient evidence of healthcare being delivered in accordance with personal plans.

21. 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:

1. The PIC will review SLT and nutrition plans and assessments as required and ensure all recommendations are in place and communicated to staff team.
2. Healthcare goals will be written in a SMART goal format.
3. All recommendations by the Speech and language therapist will be implemented.

Proposed Timescale:

1. 30/11/2015
2. 16/11/2015
3. 09/11/2015

Proposed Timescale: 30/11/2015

Theme: Health and Development

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

Residents were not supported to be involved in the preparation of their own food

22. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

1. Residents' abilities in relation to food preparation will be assessed by the keyworkers and overseen by PIC and CNM2.

2. Following the assessment the residents will be supported to be involved in the preparation of their food as per assessments.

Proposed Timescale: 30/11/2015

Theme: Health and Development

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

There was insufficient evidence of residents being offered choice at mealtimes.

23. Action Required:

Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

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

1. An increased choice and range of food will be provided to the residents.
2. The actions from the mealtime audit will be implemented and overseen by Person in Charge.
3. An educational session will be provided in the DC around basic food safety and handling

Proposed Timescale: 30/11/2015

Theme: Health and Development

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

There were insufficient staff to support residents at mealtimes.

24. Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

1. Person in Charge will ensure rosters meet the needs of the residents in particular at mealtimes.
2. Staff break times will not be roistered during residents mealtimes.

Proposed Timescale: 02/11/2015

Outcome 12. Medication Management

Theme: Health and Development

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

Prescriptions were insufficient to ensure the safe administration of medication to residents..

25. 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:

1. New medication administration records including prescription sheet is under review and will be introduced to the DC.
2. Internal Audit of medication management will be carried out.
3. Where PRN psychotropic medication is administered relevant documentation including a behaviour incident form will be completed.

Proposed Timescale:

1. 09/11/2015
2. 30/11/2015
3. 09/11/2015

Proposed Timescale: 30/11/2015

Theme: Health and Development

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

Levels of oxygen in mobile cylinder was not checked.

26. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

1. The Person in Charge will ensure that the recording of portable oxygen levels stored in the bus for emergency use will be checked and recorded as per centre checks and the recording sheets are updated to include same.

Proposed Timescale: 02/11/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The person in charge was responsible for more than one designated centre and did not satisfy the chief inspector that he can ensure the effective governance, operational management and administration of the designated centres concerned.

27. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

1. New Person in Charge will commence on 2/11/2015. New PIC will be solely responsible for one DC ensuring effective governance, operational management and administration of the DC.

Proposed Timescale: 02/11/2015

Theme: Leadership, Governance and Management

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

There were not effective management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

28. 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. New Person in Charge will commence on 2/11/2015. New PIC will be solely responsible for one DC ensuring effective governance, operational management and administration of the DC.

2. New PIC will 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.

3. Risk Register will be reviewed by PIC and updated to reflect all risks identified in the DC including those identified during the HIQA inspection.

Proposed Timescale:

1. 02/11/2015

2. 30/11/2015
3. 30/11/2015

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

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

No appropriate review of safety and quality care had been conducted by the provider.

29. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

1. An annual review of the Quality and Safety of the DC will be completed for 2015.

Proposed Timescale: 31/01/2016

Theme: Leadership, Governance and Management

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

Systems of performance management in terms of safe and quality care were not in place.

30. 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:

1. New Person in Charge will commence on 2/11/2015. New PIC will be solely responsible for one DC ensuring effective governance, operational management and administration of the designated centre.
2. Performance Development Reviews will be completed for all staff in DC1.
3. All Performance Development Reviews (PDR) will be completed with all staff on annual basis and evidenced in their Human Resource file.
4. A schedule for Professional Supervision has been developed.
5. PIC will ensure that Professional Supervision meetings take place as per Local Operational Procedure.

Proposed Timescale:

1. 2/11/2015
2. 2/11/2015
3. 25/9/2016
4. 2/11/2015
5. 30/11/2015

Proposed Timescale: 30/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was not an adequate number of staff in this designated centre with staffing levels observed as below the assessed and required levels to meet residents needs.

31. 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. The staff complement will be reviewed to ensure the assessed needs of the residents are met. All staff vacancies are under active recruitment.
2. A recruitment day has been scheduled.
3. Recruitment agencies have been commissioned to address the recruitment of dedicated agency staff assigned to DC1.

Proposed Timescale:

1. 30th November 2015
2. 28th November 2015
3. 31st October 2015

Proposed Timescale: 30/11/2015

Theme: Responsive Workforce

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

There was not consistent and continuity care provided to residents.

32. 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:

1. A recruitment day has been scheduled.
2. Recruitment agencies have been commissioned to address the recruitment of dedicated agency staff assigned to DC1.
3. Designated staff teams will be assigned to support smaller groups of residents.

Proposed Timescale:

1. 28th November 2015
2. 28/10/2015 on-going
3. 31st December 2015

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

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

All staff did not have access to appropriate training.

33. 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. Agency staff can no longer present to work in the Designated Centre unless they have received training in all mandatory areas. Request for training records are made to the agency on booking of staff.
2. The PIC will conduct an audit of staff training records and identify training needs for the DC including training in Management of Actual and Potential Aggression (MAPA).
3. Practice development workshops will be scheduled for staff providing training in;
 - The Role of the Key worker.
 - POMs/Person Centred Planning.
 - Pro-active/ re-active strategies.
 - UN Convention on the Rights of Persons with Disabilities.

Proposed Timescale:

1. 2/11/2015
2. 30/11/2015
3. 31/12/2015

Proposed Timescale: 31/12/2015

Theme: Responsive Workforce

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

All staff were not appropriately supervised within this designated centre.

34. 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:

1. Person in Charge will ensure that Professional Supervision Meetings take place as per Local Operational Procedure.
2. The Person in Charge will be based in the designated centre and will provide formal and informal supervision to staff on an on-going basis.
3. Clinical Nurse Managers will be rostered to work opposite each other Monday to Sunday; thus ensuring there is appropriate supervision in place.

Proposed Timescale:

1. 30/11/2015
2. 09/11/2015
3. 09/11/2015

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

All policies were not reviewed in line with regulatory requirements.

35. Action Required:

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

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

1. The Programme, Quality and Safety department are currently reviewing the policy on the provision of personal and intimate care.
2. The interim policy has been replaced with Safeguarding Vulnerable Persons at Risk of Abuse National Policy& Procedures

Proposed Timescale:

1. 28/02/2016
2. 28/10/2015

Proposed Timescale: 28/02/2016

Theme: Use of Information

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

All residents were not reflected in the directory of residents.

36. 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:

1. The directory of residents will be updated to meet compliance with schedule 3; identifying all residents availing of a residential service in DC1.
2. An up to date resident's guide will be furnished to each resident in DC 1.
3. The residents guide will be discussed at residents meeting (Speak Up).

Proposed Timescale:

1. 28/10/2015
2. 30/11/2015
3. 30/11/2015

Proposed Timescale: 30/11/2015

Theme: Use of Information

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

The guide prepared in respect of the designated centre did not include arrangements for visits.

37. Action Required:

Under Regulation 20 (2) (f) you are required to: Ensure that the guide prepared in respect of the designated centre includes arrangements for visits.

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

1. The resident guide will be reviewed to include visits to the designated centre.
2. An up to date resident's guide will be furnished to each resident and their representatives in DC 1.
3. The residents guide will be discussed at residents meetings (speak up).

Proposed Timescale: 30/11/2015