

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Sycamores
Centre ID:	OSV-0001875
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	SOS Kilkenny Ltd
Provider Nominee:	Francis Coughlan
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	Rachel McCarthy
Type of inspection	Announced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	2

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 July 2016 09:40	13 July 2016 19:20
14 July 2016 09:45	14 July 2016 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to inspection

This report details the findings of an announced registration inspection carried out over two days. The inspection was taken on foot of an application to register by S.O.S (Special Occupation Scheme) Kilkenny Ltd, the provider. A monitoring inspection by the Health Information and Quality Authority (HIQA) was previously carried out in the centre June 2014.

How we gathered evidence

Inspectors met with residents, staff, the person in charge, and other persons participating in management over the course of the inspection. Policies and documents were reviewed as part of the process including a sample of health and social care plans, the complaints log, incidents and accident logs, contracts of care and risk assessments. Unsolicited information received by HIQA prior to the inspection was also reviewed.

Inspectors spoke with all residents present in each of the three residential units of the centre. At all times inspectors endeavoured to respect residents' wishes and communication preferences during the conversations and followed the lead of the resident at all times. Many residents were unable to communicate verbally with inspectors. Where this was the case inspectors observed their body language and how they interacted with their peers and staff. One resident had a conversation with an inspector about their experience of living in the centre.

The resident spoken with said they liked where they lived, they could ask the person in charge or a staff member for help if they needed it and if they had a problem they felt they could go and speak to anyone. They enjoyed activities that were available to them and discussed trips they had been on.

Description of the service

The statement of purpose for the centre documented that S.O.S Kilkenny Ltd aimed "to develop services that are individualised, rights based, and empowering; that are person-centred, flexible and accountable; services that promote relationship building and social inclusion – and which are in and of the communities where residents live." Overall inspectors found that the provider was providing this service.

The centre comprised of three detached houses a short distance from each other located in the suburbs of a town in Co. Kilkenny. The centre could accommodate up to 22 adult residents. The centre provides services and support to people with intellectual disability who may have additional needs associated with having an older age profile and includes the following areas of support age related illnesses such as dementia, Alzheimer's disease, Parkinson's disease, Cerebral Palsy, Down Syndrome and visual impairment, for example.

Overall judgment of our findings

Inspectors were satisfied residents were receiving a good service where residents' choices and needs were central to the supports in place for them. However, there were a number of non-compliances found. Eleven Outcomes were found to be compliant or substantially compliant. Seven Outcomes met with moderate non compliance.

Outcome 7; Health and Safety and Risk Management, was found to be moderately non-compliant. This related to a lack of risk identification and analysis of risks that were identified. Inspectors noted a specific safeguarding risk had not been identified as posing a risk and therefore supports in place were not documented or identified. Outcome 8; Safeguarding and Safety was another Outcome that met with moderate non compliance. This judgment was given due to an allegation of financial abuse

which had been raised by staff but was not investigated at the time in line with national safeguarding policies and procedures. During the course of the inspection a preliminary safeguarding screening was carried out and a safeguarding plan was developed.

Outcome 14; Governance and Management also met with moderate non compliance. Non compliance in this Outcome related to a lack of clarity with regards to the roles and responsibilities of some of the persons participating in management of the centre. There were also improvements required in relation to the unannounced provider visits to the centre and the annual review of the centre.

These findings are discussed under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents' rights, dignity and consultation were well met in this centre. Residents' opinions, preferences and civil rights were upheld to an adequate standard. Advocacy services were available to residents and a committee had been established in the organisation. There were some improvements required relating to complaints management systems and also privacy in one instance.

Inspectors reviewed a sample of complaints for the centre and found complaints had been logged and were addressed in a timely way for most issues documented. Staff had also supported residents to log complaints which was evidence of staff supporting residents to make complaints and advocating on behalf of residents.

The centre had a complaints policy and procedure. It met the requirements of the Regulations. However, it was not centre specific and staff spoken with were not clear as to who the nominated person to deal with complaints for the centre was. Improvements were required to ensure staff and residents were clear as to whom they could approach with regards to a complaint and the delegated person nominated to deal with complaints in each residential unit of the centre.

A number of complaints logged in the centre indicated there were issues with regards to a lack of transport options for the centre. This impacted on the opportunities they had for spontaneous engagement in activities, for example, or activity options. A number of complaints had been logged by staff on behalf of residents with regards to the lack of suitable transport available to meet the needs of one resident. The provider had made adaptations to the vehicle allocated for the residential unit the resident lived in however

at the time of inspection this issue was not resolved.

Residents were consulted with regularly and participated in decisions about their care and about the running of the centre. There were regular residents' advocacy meetings organisationally which enabled residents to make plans and discuss matters important to them. A resident living in the centre was nominated to attend the advocacy meetings and bring feedback on behalf of the centre. The provider nominee had also attended some of the advocacy meetings to update residents on matters to do with the organisation. Minutes of the meetings were documented and circulated to residents.

Residents were also well informed of their rights and staff had received training in the charter of human rights for people with disability. S.O.S Kilkenny organisation has a human rights committee which comprises of one resident representative, two members of staff, one family representative. It also comprises of one legal representative, one community representative among other people. Its role is to work in an advisory capacity for the promotion of best practice in human rights for the service. It also reviews referrals made with regards to restrictive practices which were in place for some residents using the service.

The inspector observed interactions between residents and staff that were respectful and caring and were delivered ensuring that the dignity and privacy of the resident was maintained. Staff demonstrated a good knowledge of the preferences of the residents and this was supported by information in the care plans and entered into the daily records.

Inspectors noted there were systems in place to safeguard residents' finances. Residents were supported to have their own bank accounts and to access their money. Audit sheets to check residents' finances were in place and were checked weekly to ensure there were no discrepancies. Managers for the centre engaged in monthly finance audits of residents' accounts. Inspectors did note there was an allegation of financial abuse raised by staff. This is further discussed in Outcome 8: Safeguarding and Safety.

There was adequate space in the residents' rooms for clothes and personal possessions. The laundry and facilities were available for residents to manage their own laundry if they wished.

Privacy arrangements were also in place throughout the three residential units that made up the centre. Residents could lock their bedroom doors if they wished and their bedrooms were private spaces which staff were observed to respect. Similarly, toilets and bathing facilities had adequate provisions in place to ensure privacy and dignity for residents in the most part. However, the toilet facility in one residential unit did not have a privacy lock.

This was brought to the attention of the person in charge and provider at the feedback meeting at the end of the inspection. Shortly after the inspection the person in charge contacted the inspector with evidence that a privacy lock had been fitted to the toilet door to address the issue.

Judgment:
Substantially Compliant

Outcome 02: Communication

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

Theme:
Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Overall, residents' communication needs were adequately met in the centre.

Inspectors observed that there were an ample number of radios, televisions and pictorial aids in each residential setting to ensure residents' communication needs were being met and accessible to them.

Inspectors reviewed resident's personal plans which highlighted resident's communication needs. Staff were aware of the communication needs of each resident and inspectors observed staff using pictures to communicate with residents what was happening next or to support them in choosing an activity.

Residents requiring supports had received review by speech and language therapists (SALT) where required. Evidence of these reviews were maintained in residents' personal plans. External agencies were also involved in enhancing the communication needs of residents, for example the National Council for the blind Ireland (NCBI) had visited the centre to give advice and guidance for the support of residents with visual impairment.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community

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

Theme:
Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were supported to maintain contact with their families, develop and maintain friendships.

Families and friends were encouraged to visit the centre and residential units had space available for residents to meet with families in private. There was a policy on visitors available and there was a sign in book for visitors in the house.

Residents' families and representatives were also actively encouraged to participate in personal planning meetings for residents where appropriate.

Some issues impacted on residents accessing their community this was related to transport resources. This is further discussed in Outcome 16: Resources.

Judgment:

Compliant

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):

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

Findings:

There were policies and procedures in place to guide the admissions process. The process was also described in the statement of purpose. Actions from the previous inspection had been addressed.

Policies and procedures for admission to the centre outlined prior to admission, prospective residents and their family were encouraged to visit the residential setting and meet the relevant staff and/or manager. In addition, the opportunity was provided for support needs to be identified/agreed and other issues including rent and other financial matters to be also discussed in advance. In addition, the requirement to take into account the need to protect residents from abuse from their peers was also outlined in the admission policy.

All residents had been issued contracts detailing the support, care and welfare of residents and details of the fees to be charged regarding residents care and welfare. From the sample reviewed, each resident had a contract in place that had been signed by the resident or their representative as appropriate. Contracts detailed a number of the costs/charges to be paid including rent and transport costs more information had

been added to the contracts to give a clearer outline of all fees charged to residents.

Judgment:

Compliant

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:

There was evidence that all residents had a personal plan in place which comprehensively outlined residents' needs and personal goals. However, there were some improvements required to ensure they met with some matters as set out in the regulations.

Personal plans began with a service user profile containing the important information about each resident. They also contained an assessment of need and associated support plans in place for needs identified for example in the areas of behaviour support and nutritional management. In addition daily records were documented for each resident and also maintained in their personal plans. Person centred planning meetings were held on an annual basis, or more frequently if required.

There was evidence of multi-disciplinary input and review in residents' personal plans. Inspectors noted residents had received review by occupational therapists, speech and language therapists, psychologist, psychiatric and behaviour support specialist intervention where required. Reviews, recommendations and support plans were maintained in residents' personal plans and guided staff practice.

Residents were assigned key workers. The key worker's responsibility was to meet with residents and set goals to be achieved for the year. Goals were set with residents, and there was evidence that they were supported to choose goals they would work towards. However, there were some instances where goals that had been set had not been met.

For example, a resident had expressed a wish to visit their parent's graveyard. This goal had been set in January 2016. Since then there had been two entries documenting the goal had not been achieved due to adverse weather conditions. Another activity identified was to attend music sessions in the town this had only happened once in six months. There was no review of why the goal had not been met and plans in place to ensure it could be. This was not acceptable.

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):

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

Findings:

Overall the three residential units that comprised the centre were suitable to meet the needs of residents that lived there. However, one of the three residential units was not decorated in a homely way and appeared clinical in appearance.

The centre consisted of three separate houses located in mature residential areas convenient to amenities such as shops, parks and post offices. Premises were reasonably accessible, bright, well ventilated, and had central heating.

There were adequate showers and toilets with assistive equipment in place. Where required residents were provided with beds and equipment to ensure staff could provide adequate mobility and sleeping supports, for example inspectors noted residents had specialised beds, chairs and ceiling hoists. Each resident had their own bedroom and residents that showed inspectors their rooms stated that they were happy with the living arrangements. Inspectors noted residents had personalised their rooms with photographs of family and friends and personal memorabilia.

Equipment for use by residents or people who worked in the centre including wheelchairs was in good working order and records were available in relation to servicing of such equipment. There were suitable accessible grounds/outside areas and a variety of suitable pathways for residents use. There were car park areas and a number of suitable garden areas with seating/tables provided for residents use to the rear of each premises. The grounds were kept safe, tidy and attractive and inspectors observed residents and staff using these facilities.

The provider had made changes to the living environments of the residential units since the previous inspection by adding visitor's rooms in two of the three residential units. Previously in one residential unit inspectors had to walk through a bedroom to access another residents' bedroom. To resolve the issue the provider had converted a sharing bedroom to a single bedroom and converted a staff sleepover room to a resident's bedroom thus providing both residents with their own bedrooms.

While improvements had occurred inspectors found one of the residential units did not provide enough communal space options for residents to use. The communal space for residents comprised of a living and dining room space which appeared somewhat crowded and noisy when all residents were in it. Residents required access to other living spaces in their home so they could space to meet visitors and family in private other than their bedrooms, for example.

Inspectors were informed the white colour scheme of the residential unit was intended to promote a low arousal environment which could support residents living with dementia. However, inspectors were not satisfied with this rationale. There were many corridors in the premises all of which were painted white. This could present as an issue for residents with dementia particularly residents presenting with visual impairments associated with the disease which impacts on depth perception. There were minimal visual cues to assist residents with dementia to navigate their home, for example, colour contrasting or colour coded spaces and signs.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

Findings:
The health and safety of residents, visitors and staff was adequately promoted in relation to fire safety, infection control and manual handling. However, some systems in place were not robust enough. Risk management systems in relation to falls prevention and their management were not adequate. Risks identified had not been analysed to identify the level of risk they posed and if the control measures in place were appropriate.

The risk management policy met the requirements of the Regulations and covered the matters set out in Regulation 26 including identification and management of risks, the measures in place to control identified risks and arrangements for identification, recording, investigation and learning from serious incidents.

There was an up-to-date health and safety statement for the centre in line with the centres procedures. Hazards were identified with control measures in place and documented in a risk register. However, not all risks had been identified in the centre. Inspectors identified a safeguarding risk in the centre relating to inappropriate sexualised behaviour. However, there was no support planning or risk assessments in place with regards to the likelihood the risk could occur again or in what situations.

Inspectors were not assured there were adequate risk management supports identified to support the resident when they accessed the community or when there were visitors to the centre, for example. While inspectors were assured by the provider and director of services that the risk of the behaviour occurring was low, the risk had not been assessed in any formalised way in consultation with relevant allied health professionals, for example.

Where personal risks to residents had been identified they had not been assessed in line with the organisations policies and procedures for risk management. For example, some residents presented at risk of choking due to compromised swallow, however, the severity and likelihood of the risk occurring had not been assessed.

Inspectors identified a number of residents in all three residential units of the centre were at risk of falls. Prior to the inspection a notification had been also been received by the Chief Inspector notifying a resident following a fall had received a concussion. Inspectors reviewed the centre's systems in place for the management of falls risks however, they were inadequate. Management of falls was more reactionary than preventative. Falls prevention planning was not implemented afterwards to prevent the likelihood of the incident happening again.

Fire policies and procedures in place were comprehensive and centre-specific. Fire evacuation notices and fire plans were displayed in each residential unit. Fire drills had taken place at regular intervals. All staff working in the centre had received fire safety training.

Individual personal evacuation management plans were documented for residents and implemented as part of fire drills in each residential unit. An inspector examined the fire safety registers in the centre which detailed services and tests all of which were up-to-date. They also detailed fire safety checks in each residential unit which were also up-to-date.

All fire evacuation doors were fitted with thumb turn devices which could be used to open doors in the event of a fire. This ensured residents and staff could evacuate from the premises without the necessity of a key but still ensuring that the premises was secure. All doors in the three residential units that made up the centre appeared to be heavy set fire compliant doors. This promoted good fire containment measures. Emergency lighting was present throughout each residential unit of the centre.

Infection control measures were adequate given the purpose and function of the centre. Cleaning schedules were in place and these were to be completed by staff on an on-going basis. Hand washing facilities in the centre were adequate. Hand wash and drying facilities were available to promote good hand hygiene in each residential unit of the centre. Colour coded mops and buckets were designated to clean specific areas in the centre to prevent cross contamination of surfaces.

To address infection control issues for soiled linen alginate bags were now used to launder soiled linen ensuring appropriate infection control systems were in place. There were also individual continence disposal bins maintained in residents' bedrooms which ensured soiled incontinence wear was suitably disposed of and wrapped appropriately before bringing out to the waste disposal receptacles for the residential units.

All staff had attended up to date training. Appropriate equipment was supplied in each residential unit which ensured staff could engage in manual handling safely with residents.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

There were appropriate policies and procedures in place to protect residents from experiencing abuse, measures in place also ensured staff working in the centre understood appropriate procedures for the response to allegations of abuse and detection of signs of abuse. Actions from the previous inspection had been addressed adequately. However, there were improvements required.

Inspectors identified a safeguarding risk for which there were inadequate risk assessments and support plans in place. In another instance an allegation of financial abuse was not responded to in line with policies and procedures for safeguarding vulnerable adults. Some restrictive practices required review.

There was a policy in place on the prevention, detection and response to abuse and all staff had received training. Staff spoken with and the person in charge outlined the procedures they would follow should there be an allegation of abuse. The person in charge of the centre was also a qualified social worker with training in safeguarding vulnerable adults and implementation of the national policy on safeguarding.

Residents were encouraged to advocate for themselves, know their rights and encouraged to make complaints, all of which provided residents with skills to safeguard themselves and their peers.

Prior to the inspection HIQA received information from a concerned person. Details of the concern were reviewed during the inspection. Inspectors however, did not find evidence to substantiate the concern based on observations, documentation reviewed and discussion with the person in charge, persons participating in management of the centre.

However, on reviewing staff meeting minutes, during the inspection, inspectors did note a concern had been raised by staff that a resident may be at risk of financial abuse. While staff had raised the issue in line with their safeguarding training, the response to the allegation was not robust and not in line with safeguarding national policy. There had been no preliminary screening, referral to a designated officer or investigation carried out.

During the course of the inspection the person in charge completed a preliminary screening for the allegation and drafted a safeguarding plan for the resident including an action whereby the resident would be reimbursed money owed to them on a specific date.

While inspectors were assured there was a comprehensive response to the allegation they were concerned the allegation had not been responded to at the time it was raised. This provider and person in charge were required to ensure all allegations of abuse were responded to in line with the organisation's policy and national safeguarding standards.

Residents were provided with behavioural and therapeutic support that promoted a positive approach to behaviour that challenges. There was a policy and systems in place for the management of behaviours that challenge. Residents were also supported to avail of psychiatric services if required.

Residents who could display behaviours that challenge had behaviour support plans in place. Possible triggers and appropriate interventions and avoidance mechanisms were documented. All staff had received training in response to behaviours that challenge and potential aggression.

A restraint free environment was promoted in general throughout the centre. Inspectors observed where residents required bed rails, for example a bed rail risk assessment was carried out and necessary risk controls were in place. In some instances where bed rails were deemed not to be suitable alternative interventions were in place such as low-low beds and crash mats beside the bed to reduce the risk of injury should a resident roll

from the bed. This was evidence of a restraint free environment being promoted in the centre.

However, there were some improvements required in relation to restrictive practices. In one residential unit a metal gate was used to prevent some residents from entering the kitchen when meals were being cooked due to a risk of them scalding themselves. While there was merit in ensuring residents were not at risk of injuring themselves this was not the least restrictive intervention. There was no evidence which indicated other alternatives had been trialled..

Some residents living in the service required a 'low arousal' environment in order to mitigate risk of being exposed to triggers which could cause them to engage in behaviours that challenge. At the time of inspection in order to support a resident requiring this type of environment they were supported to enter the premises through an alternative entrance and to use a quieter part of the premises to facilitate their needs. The provider informed inspectors that they did not envisage that the arrangement would be a long-term living arrangement for the resident and hoped to procure a more suitable living environment for them in the future.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

While the person in charge demonstrated knowledge of her responsibilities to notify the Chief Inspector, not all restrictive practices used and minor injuries that had occurred in the centre, such as falls, had been notified to the Chief Inspector on a quarterly basis.

An allegation of financial abuse had not been notified to the Chief Inspector. Subsequent to the inspection the inspector received the notification.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents' general welfare and development were supported to a good standard in the day services.

Some residents were involved in a local radio station in their day service. There was also an internal magazine developed every quarter containing events in the centre including resident's birthdays, exhibitions and any outings.

Residents attended day services in accordance with their assessed needs. Various activities they engaged in included rug making, pottery, art, working in the canteen, running a radio station and horticulture.

The mission and ethos of the organisation the centre was part of was to encourage and support residents to have meaningful employment and engagement in purposeful meaningful activities. The provider nominee had plans in place to develop 'hubs' in the local town where residents could meet and engage in activities there meeting their peers and the community within the community as opposed to a day service outside of the town on the organisation's campus.

Judgment:

Compliant

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:

Overall residents healthcare needs were managed to an appropriate standard. However, there were some instances where residents were unable to attend healthcare appointments.

Residents were supported to access community primary healthcare services, for example going to their own general practitioner (GP), chiropodist, community psychiatry services and speech and language therapy services. Staff accompanied residents to appointments where required. Residents also used out of hours GP services who could attend to residents in their own home if required. Residents also availed of the services of social work where required. Personal plans documented records of residents' medical visits, referrals and appointments.

There was evidence that some residents' health had improved greatly and were now mobile where previously they had been confined to using a wheelchair most of the time. Staff spoken with were knowledgeable with regards to residents' healthcare needs in relation to prevention of pressure ulcers and appropriate positioning while in bed, for example to prevent the development of pressure ulcers and/or contractures from occurring.

Due to a lack of transport resources residents had not been able to make some medical appointments. This is actioned in Outcome 16: Use of Resources.

Inspectors noted that residents were encouraged to make healthy eating and living choices. Residents were involved in cooking meals in their home and meal choices in their homes. Fridges and cupboards were well stocked with fresh, frozen and dry goods and condiments for making home cooked meals. Each residential unit had adequate kitchen and dining facilities to cater for the needs of the number of residents living there.

Where residents required nutritional supports they had appropriate interventions in place, for example some residents required PEG (percutaneous endoscopic gastrostomy) feeds to support their nutritional intake. Inspectors observed residents were afforded privacy and comfort when receiving their PEG nutrition. Residents were prescribed this nutrition through liaison with their GP and other relevant allied health professionals such as dietician and/or speech and language therapist.

Residents' weights were documented. Policies or procedures were in place to direct staff in how residents' nutrition should be monitored, reviewed and what to do if nutritional risk was identified.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Overall, residents were protected by the centre's policies and procedures for medication management.

All prescribing and administration practices were in line with best practice guidelines and legislation and systems were place for reviewing and monitoring safe medication practices.

Staff involved in the administration of medications had completed safe administration of medication training to ensure they had skills and competencies to administer medications to residents safely. Inspectors observed medication administration procedures in two of the three residential units during the course of the inspection and observed them to be safe and in line with best practice.

Staff who spoke to the inspectors were knowledgeable about the residents' medications and demonstrated an understanding of appropriate medication management and adherence to professional guidelines and regulatory requirements.

Residents' medication were stored securely in all three residential units of the centre. A medication fridge was available for the storage of medications requiring refrigeration where required.

Medication administration charts reviewed were clear and distinguished between PRN (as required), short-term and regular medication. There were no controlled drugs in use at the time of this inspection. Where residents required their medications to be crushed or in liquid format due to swallowing difficulties, for example, this was clearly indicated on the medication administration charts. Maximum dosage of PRN medications was indicated on medication administration charts.

Medication management systems were audited as part of the six monthly unannounced visits of each residential unit in the centre. Actions were identified where necessary and followed up on by the person in charge or person participating in management where necessary.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

A written statement of purpose was available and it broadly reflected the day-to-day operation of the centre, the services and facilities provided in the centre.

The person in charge confirmed that he kept the statement of purpose under review and provided inspectors with a copy of the most up to date version.

However, the statement of purpose did not outline adequately the level of training, enterprise and general development supports the service provided to residents which inspectors observed to be the case during the inspection. Following the inspection the provider submitted an updated statement of purpose which addressed this non compliance.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Overall, there were adequate systems in place to ensure effective governance and management of the centre. There were some improvements required to ensure unannounced six monthly visits by the provider effectively monitored the compliance of

the centre against the Regulations.

S.O.S (Special Occupation Scheme) Kilkenny Ltd is a registered company and a voluntary not for profit body. It is also a registered charity. The service is funded by the Health Service Executive with whom it has a service level agreement which is reviewed annually. S.O.S Kilkenny Ltd is managed by a Voluntary Board of Management.

The provider nominee who is the CEO for the service reports to the Board regularly. Some of the items they report to the board include an overview of accidents and incidents in the designated centres of the service. Family feedback surveys are reported to the board also. Other items discussed are resourcing, budgets and agenda items and feedback from residents' advocacy meetings.

The person in charge worked full-time and had worked in disability services for many years. The person in charge is a qualified social worker with extensive experience in the area of safeguarding and child protection. She demonstrated knowledge of the regulations and her role and responsibility with regards to the regulations during the inspection

The person in charge and provider were actively engaged in the governance and operational management of the centre on a daily basis. They both had an excellent knowledge of the personalities and needs of the residents that lived in the centre and presented as persons passionate in ensuring residents received a person centred service where their rights were upheld.

The management team for the centre consists of the provider nominee, the director of services, person in charge, one CNM2 (Clinical Nurse Manager) and one CNM1. While there was a clearly defined management structure for the centre and a robust governance system the lines of responsibility and accountability for the direct line managers for the centre were not clear.

There was some overlap in the roles and responsibilities for the managers in the centre which led to instances where managers were unclear as to who had direct responsibility to carry out some procedures in the centre. For example, it was not clear who had direct oversight of staff supervision and appraisals, equally with regards to the risk register for one residential unit it was not clear which manager had oversight to ensure it was updated and all risks, including safeguarding risks, were identified and documented.

Furthermore, there were no specific job descriptions maintained for the person in charge, CNM2 and CNM1 maintained in their personal files which further evidenced the lack of clarity with regards to managements' roles and responsibilities for the centre. A non compliance for this is given in Outcome 17: Workforce.

Unannounced six monthly visits of all residential units that comprised the centre had been carried out. The visits had brought about some changes in the centre such improvement in medication management practices with regards to PRN (as required) medication protocols. They had also identified where some structural work was required and staff updating with regards to safeguarding policies and procedures. However, the unannounced visits and annual report had been carried out by the person in charge and

not the provider or a nominated person by the provider. While the audits were comprehensive in nature they could not evaluate the effectiveness of the person in charge in their role as they were carried out by the person in charge.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of his responsibility to notify the Authority of the absence of the person in charge. To date this had not been necessary. Appropriate deputising arrangements were in place should the person in charge be absent from the centre.

Judgment:

Compliant

Outcome 16: Use of Resources

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

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

Overall the centre was provided with adequate resources to meet the needs of residents in terms of staffing and assistive equipment. However, the centre was not adequately resourced with transport facilities for residents. Inspectors found an instance where a resident had been unable to attend a medical appointment due to a lack of transport facilities in the centre that met their needs.

As outlined in Outcome 1, residents had also brought the lack of transport resources to their advocacy committee meetings and logged complaints.

Judgment:

Non Compliant - Moderate

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:

Inspectors were satisfied there were good recruitment practices in place and adequate numbers of staff in the most part to provide for residents' support needs. Staff observed and spoken with during the course of the inspection presented as caring people with a good knowledge of residents.

However, some actions which were found on the previous inspection had not been adequately addressed this related to documentation maintained in staff files. There were some training gaps for staff also. The person in charge was required to establish a formalised supervision and appraisal system for all staff working in the centre.

There was a policy on recruitment and selection of staff and a staff handbook in place, which outlined procedures in relation to all aspects of staff's employment with the service. Inspectors reviewed a selection of staff files and noted while there was evidence of vetting. However, not all the documents as required under Schedule 2 of the regulations 2013 were maintained in staff files.

As referred to in Outcome 14 of this report, a number of staff files did not contain records of the position the person holds, or held, at the designated centre, the work the person performs/performed. For example, the staff file for the person in charge did not contain a record to indicate her role as person in charge and still referred to her holding the position of social worker in the service which had been her previous role.

During the inspection, inspectors observed the person in charge and staff interacting and speaking to residents in a friendly, respectful and sensitive way. Based on observations of inspectors, staff members were knowledgeable of residents' individual

needs. Residents spoke very positively about staff saying they were caring and looked after them very well. The inspectors spoke to staff on duty during the inspection. Staff spoken with presented as competent and experienced and were aware of their roles and responsibilities demonstrating a good understanding of safeguarding procedures and the health care needs of residents, for example.

Some staff had received a formalised appraisal by CNM 2 for the centre (person participating in management) However, not all staff had received a supervision session. It was not clear as to the rationale for not all staff having received a supervision meeting. This required improvement and implementation.

Training records confirmed that staff had received training in fire safety, safeguarding of vulnerable adults, first aid, management of challenging behaviours, medication management and safe manual handling procedures. However, there were some further improvements required to ensure staff had the necessary skills to provide safe and appropriate care and support for residents. Not all staff had received training in the use of emergency rescue medication for epilepsy. Staff also required training in the area of dysphagia management to support residents with compromised swallows who could be at risk of choking.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found there were appropriate practices in place for the management of records and documentation in the centre.

Policies and Procedures are in place as required by schedule 5 of the Regulations, they are reviewed and updated to reflect best practice and at intervals not exceeding three years.

Complete records were maintained in the centre and residents are able to access their own records. There is a guide to the centre available to residents and visitors. A copy of the statement of purpose, annual report and previous Health Information and Quality Authority (HIQA) report were available.

A directory of residents was available for each resident residing in the centre.

The designated centre is adequately insured against accidents, or injury to residents, staff and visitors.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Ann-Marie O'Neill
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:	The Sycamores
Centre ID:	OSV-0001875
Date of Inspection:	13 July 2016
Date of response:	19 September 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The complaints policy was not centre specific and staff spoken with were not clear as to who the nominated person to deal with complaints for the centre was. Improvements were required to ensure staff and residents were clear as to whom they could approach with regards to a complaint and the delegated person nominated to deal with complaints.

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

1. Action Required:

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

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

SOS has a complaints policy and as per our other policies it applies to the organisation as a whole of which this Designated Centre is part of. SOS also has an easy read version of this policy. This policy nominates the residential manager as a complaints officer that is the nominated person to deal with complaints for their area of responsibility. The senior social worker is the nominated complaints officer for the whole organisation.

Each location has complaints forms visibly displayed. The compliant form will be amended to show the local manager for dealing with complaints.

Training will be provided to staff and residents on the complaints policy and the amended form.

Proposed Timescale: 30/01/2017

Theme: Individualised Supports and Care

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

A number of complaints had been logged by staff on behalf of residents with regards to the lack of appropriate transport for a resident living in one residential unit of the centre. However, at the time of inspection this issue was not resolved.

2. Action Required:

Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

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

SOS is providing transport to facilitate activities for the residents in this centre.

Proposed Timescale: 16/09/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

There were some instances where goals that had been set had not been met. There was no review of why the goal had not been met and plans in place to ensure it could be.

3. Action Required:

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

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

Goals set will be reviewed by key workers and their line manager following the residents three monthly review of their personal outcomes planning.

If the key worker and line manager are unable to ensure the goal is met they will bring it to the attention of the PIC as there may be a resource implication to be resolved.

Goals set will be put on the monthly team meeting agenda for team planning.

Proposed Timescale: 17/10/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

There were many corridors in the premises all of which were painted white. This could present as an issue for residents with dementia particularly residents presenting with visual impairments associated with the disease which impacts on depth perception.

4. 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:

We will seek the advice of a dementia nurse specialist to advise on the optimum decoration of the corridors to suit the needs of all residents there.

Proposed Timescale: 21/11/2016

Theme: Effective Services

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

One of the residential units did not provide enough communal space options for residents to use.

5. 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:

We have sought and been approved planning permission for an extension to this house to facilitate the provision of additional communal space (2015).

Funding for this extension is being applied for under the CAS scheme. On receipt of funding the necessary building works can be completed.

Proposed Timescale: 31/12/2018

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:

Management of falls was reactionary rather than preventative and residents identified at risk of falls did not have falls prevention plans in place to mitigate risks of them falling.

Inspectors identified a safeguarding risk in the centre relating to inappropriate sexualised behaviour. However, there was no support planning or risk assessments in place with regards to the likelihood the risk could occur again or in what situations.

Risks identified had not been assessed in line with the organisation's risk management policies and procedures.

6. 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:

Risk Management Policy in Place.

In relation to the historical inappropriate sexualised behaviour a risk assessment was completed and will be reviewed in line with policy.

In relation to Falls SOS are developing a slips trips and falls policy this will include plans to mitigate risks of falling. When completed training will be provided to staff on this policy.

Proposed Timescale: 28/02/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

In one residential unit a metal gate was used to prevent some residents from entering the kitchen when meals were being cooked due to a risk of them scalding themselves. There was no evidence which indicated other alternatives had been trialled.

7. Action Required:

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

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

Currently the gate is used for the shortest duration possible to promote the safety and welfare of one person whom is only present there on a part time basis. Alternative risk management strategies will be trialled to ascertain if a less restrictive option can be used.

With the planned extension of the house (Action 5) the plan is to relocate the cooker thus removing the necessity of any restriction to the main kitchen/dining room.

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

An allegation of abuse had not been responded to at the time it was raised. This provider and person in charge were required to ensure all allegations of abuse were responded to in line with the organisation's policy and national safeguarding standards.

8. Action Required:

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

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

All allegations of abuse will be responded to in line with the SOS Policy on Safeguarding Vulnerable Persons at Risk of Abuse.

Proposed Timescale: 16/09/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Not all restrictive practices used in the centre had been notified to the Chief Inspector on a quarterly basis in line with the matters as set out in the Regulations.

9. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
All restrictive practices will be notified to HIQA at the end of each quarter.

Proposed Timescale: 16/09/2016

Theme: Safe Services

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

Not all injuries that had occurred in the centre had been notified to the Chief Inspector on a quarterly basis in line with the matters as set out in the Regulations.

10. Action Required:

Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

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

All injuries including falls will be notified to HIQA at the end of each quarter.

Proposed Timescale: 30/10/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The lines of responsibility and accountability for the direct line managers of the centre were not clear.

11. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

Details of each managers responsibilities identifying the lines of authority and accountability and specifies roles will be documented and communicated to managers and staff.

Proposed Timescale: 21/12/2016

Theme: Leadership, Governance and Management

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

While the six monthly audits and annual review had been completed they could not evaluate the effectiveness of the person in charge in their role as they were carried out by the person in charge.

12. Action Required:

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

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

The Quality Officer has been assigned responsibility for the carrying out the service provider six monthly unannounced inspections and the service provider annual review of the quality and safety of care and support in the designated centre.

Proposed Timescale: 16/09/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

There was an issue in relation to lack of transport resources for the centre which had direct negative impact on some residents in particular whereby they could not attend medical appointments or engage in social activities outside of the centre.

13. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

Transport will be provided to ensure medical appointments are kept. Transport will be provided to facilitate social activities by a combination of service vehicles, staff cars and taxi's.

Proposed Timescale: 16/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

A number of staff files did not contain records of the position the person holds, or held, at the designated centre, the work the person performs/performed.

14. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

Staff files for the designated centre will be updated to include records of the position the person holds, or held, at the designated centre, the work the person performs/performed.

Proposed Timescale: 01/12/2016

Theme: Responsive Workforce

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

Not all staff had received a supervision session. It was not clear as to the rationale for not all staff having received a supervision meeting.

15. 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:

Appraisals of staff will be completed so that each staff member will have a supervision meeting.

Proposed Timescale: 31/01/2017

Theme: Responsive Workforce

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

Not all staff had received training in the use of emergency rescue medication for epilepsy.

Staff also required training in the area of dysphagia management to support residents with compromised swallows who could be at risk of choking.

16. 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:

Training will be provided to ensure all staff are trained in the areas of the use of emergency rescue medication for epilepsy and dysphagia management.

Refresher training will be provided to staff as required in the future.

Proposed Timescale: 30/11/2016