

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Sea Road Services
<b>Centre ID:</b>	OSV-0002624
<b>Centre county:</b>	Sligo
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Bernadette Donaghy
<b>Lead inspector:</b>	Anne Marie Byrne
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	8
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 19 April 2017 09:30 To: 19 April 2017 16:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

Following a review of compliance across the Health Service Executive (HSE) CHO Area 1, the Health Information and Quality Authority (HIQA) raised concerns with the HSE National Director, in relation to the significant and on-going levels of non-compliance in centres operated by the HSE in CHO Area 1.

The Chief Inspector of Social Services required the HSE to submit a plan to the Authority which described the actions the HSE would take, in order to improve the quality of life for residents living in the services in CHO Area 1, the overall safety of the services operated by the HSE in that area and to improve and sustain a satisfactory level of compliance across the five core outcomes of concern.

In December 2016 the HSE submitted a governance plan to HIQA. The plan described the enhanced governance and leadership arrangements and actions that the HSE intended to take by 13 June 2017, in order to improve the overall levels of compliance and quality of life for residents in CHO Area 1.

In response to this plan, HIQA has developed a regulatory programme of inspections to verify the effectiveness of this plan in improving the quality of life for residents and to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with Disabilities Regulations 2013) (hereafter called the Regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the

Standards).

How we gathered our evidence:

The inspector met with six residents, three staff members, the assistant director of nursing, the person acting on behalf of the provider and the person in charge as part of the inspection process. Residents were able to communicate with the inspector, with one resident speaking one-to-one with the inspector. The centre is situated close to Sligo town and consists of two houses, which are within close proximity of each other. Both houses were visited by the inspector as part of the inspection. The inspector also reviewed practices and documentation, including four residents' files, three staff files, action plan reports, policies and procedures, fire management related documents and risk assessments.

Description of the service:

This centre is managed by the Health Service Executive (HSE) and provides residential services to people with learning disabilities who present with medical, sensory, physical and mental health needs. The service can accommodate male and female residents, from the age of 18 years upwards. One of the centre's houses provides support to four male residents, and the second house provides support to four female residents. One of the centre's houses was for sale at the time of the inspection. The provider representative gave satisfactory assurance that arrangements were in place to safeguard residents after the sale, with alternative accommodation being sourced by the provider. Remedial and building works were taking place in the centre on the day of the inspection. The person in charge informed the inspector that these works were being completed following actions required from the centre's previous HIQA inspection and from the centre's most recent fire assessment report.

The person in charge had overall responsibility for the centre and was supported in her role by the provider and through the recent appointment of an assistant director of nursing to the service. The person in charge works directly in the centre in an administrative capacity, and visits the centre's houses each day to meet with staff and residents. Both houses are two-storey detached residences, with each house having a communal kitchen, dining area, sitting room and bedroom spaces for residents.

Overall judgment of our findings:

The provider had completed some of the actions from the previous inspection report from October 2016, with some actions not due for completion until the end of April 2017. However, further improvements were required following this inspection. The inspectors found major non-compliance in two of the outcomes inspected, two outcomes in moderate non-compliance and one outcome compliant with the regulations. These outcomes relate to social care needs, health, safety and risk management, safeguarding and safety, governance and management and workforce.

The findings and their actions are further outlined in the body of the report and the action plan at the end of this 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 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:**

Residents were found to have a comprehensive assessment of their health, personal and social care needs and these assessments were reviewed on a regular basis. Residents had opportunities to regularly engage in social activities. Staff spoken with were familiar with residents, their goals and how they were progressing towards achieving these goals. Actions required from the previous inspection were found incomplete at the time of this inspection. The inspector found some residents' social care choices were not fully supported where minimum staff levels were in place. In addition, improvements were required to identifying those responsible for supporting residents to achieve their personal goals.

On the day of inspection, some residents were preparing to go on a mid-week break. The inspector met with these residents who said that they are regularly supported by staff to attend local amenities, day-centres, work placements, social outings, restaurants, public houses and community based events. Some residents informed the inspector that staff support them to independently access local transport services into the nearby town. Other residents spoke of how they enjoyed dancing and were regularly supported by staff to engage in this activity.

There were separate staffing arrangements in place for each house within this centre. The inspector found, in one of the houses, that there were arrangements in place for residents to have additional staff support at weekends to enable them to access local amenities if they wished. However, the inspector found that in the other house within the centre this support arrangement was not in place, which impacted on the social

opportunities experienced by residents living in this house. For instance, although there was consistency in the scheduling of activities for all residents to participate in at weekends, staff told the inspector that where residents residing in the second house did not all wish to engage in the planned activity at weekends, the current staff arrangement didn't always support these residents to choose to do different social activities.

There was a system in place to ensure residents' personal plans and personal goals were reviewed on an annual basis, and a key worker system was in place to support residents with this review. Residents were actively involved in the review of their personal plans and goals and they also had access to their personal plans. Some residents told the inspector that they had personal goals in place, and talked about the progress they had made in achieving these goals. The provider had categorised residents' personal goals into long-term, medium and short-term goals. Action plans for these goals were found to be concise, clearly outlined the objectives of goals, were regularly updated and identified the next date for review. Although the provider demonstrated that residents were regularly supported by the staff team to achieve their goals, no named person was identified with this overall responsibility to ensure that residents were supported to achieve their goals.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Effective Services

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

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

**Findings:**

There were some systems in place to manage and review the fire safety and risk management processes within the centre. Some actions required from the previous inspection report were completed, however; not all actions required were due for completion at the time of this inspection. The inspector found that further improvements were required to the centre's fire and risk management processes.

Each house within the centre was conducting regular fire drills. These drills were found to include all residents and staff and records of these drills demonstrated that residents could be successfully evacuated from the centre. Some residents in the centre presented with hearing needs and assistive technology was in place to support their evacuation. The inspector noted that a number of additional fire drills had been carried out by the provider to assess the effectiveness of these assistive technologies. The person in charge informed the inspector that additional measures were being implemented to

further support these residents, in the event of an evacuation. Personal evacuation plans were in place for each resident and these informed on the support required by the resident in the event of an evacuation from the centre; however they did not guide on the evacuation arrangements for residents residing in upstairs accommodation. A review of the staff training matrix demonstrated all staff had received up-to-date training in fire safety at the time of this inspection.

The centre had regular maintenance work completed on all fire fighting and fire detection systems, and records of these were available to the inspector to review. However, the inspector found that some fire safety systems in the centre were inadequate including:

- emergency lighting was not provided to the exterior of the centre to guide staff and residents safely to the fire assembly point.
- although fire exits in the centre were found to be free from obstructions, some access points from the rear of the centre to the fire assembly point was found to be blocked on the day of the inspection.
- the fire procedure for the centre did not inform staff of what to do in the event of an upstairs evacuation
- there was some evidence available that weekly fire checks were completed; however, there was no record of such checks available to the inspector for one of the houses in the centre since March 2017. The person in charge informed the inspector that she was aware of this gap in practice and was in the process of rectifying this.
- there was a separate fire alarm system in place in each house within the centre; however, not all systems adequately identified the fire zones within the house to alert staff to the location of the fire.

An assessment of the centre's fire compliance was completed in July 2016 and this report was available to the inspector. The report identified a list of works which were required to be completed to bring the centre back into compliance with fire safety standards. Some of these works were identified as requiring a high priority, recommending completion within three to six months of the report being issued. Some of these high priority works had not been completed at the time of this inspection. The person in charge and the provider informed the inspector that the remaining works were currently in progress, with an estimated timeframe for completion in May 2017.

The person in charge was in process of implementing a new risk management framework for the centre at the time of this inspection. This framework identified various organisational risks that required assessment, ongoing monitoring and review. The framework was also found to guide on the risks identified, the current controls in place, those responsible for the ongoing review of the risk, the overall risk rating and the date the risk was next due for review. However, the inspector found not all risks had additional control measures identified to assist in the mitigation of the identified risk. For example, where the risk of intrusion to the centre was assessed, the risk assessment failed to identify what controls were required to support the centre, its staff and residents in the event of a break-in at the centre. Residents' specific risk assessments were found to be in place; however, some of these were not reviewed in line with their scheduled review dates. In addition, risk assessments completed for residents who wished to smoke did not consider the assessment of the residents' safety while smoking.

**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):**

No actions were required from the previous inspection.

**Findings:**

There were systems in place to protect residents from being harmed or suffering abuse. Measures were in place to support residents experiencing behaviours that challenge. There were no actions required from the centre's previous inspection.

There were residents experiencing behaviour that challenges in the centre, and the support of a behavioural specialist was available to staff on the management of these behaviours. Behavioural support plans were in place and the inspector found these were developed in a multi-disciplinary manner, and provided staff with guidance on the recommended pro-active and reactive strategies to be implemented. Staff spoken with were very familiar with these behaviours and of their responsibilities to support these residents. All staff had received up-to-date training in the management of behaviours that challenge, with two staff scheduled to receive refresher training in May 2017.

Staff had received up-to-date training in safeguarding. There were no safeguarding plans or restrictive practices in place at the time of inspection.

**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:**

There were no actions required in relation to this outcome from the centre's previous inspection. However, on this inspection it was found that improvements were required to the governance and management arrangements to ensure effective monitoring of action plan deadlines. In addition, the inspector found the person in charge did not have appropriate garda vetting in place.

The person in charge had overall responsibility for the centre and was supported in her role by the provider, staff nurses and the assistant director of nursing. The person in charge demonstrated a clear understanding of her role, was knowledgeable of residents' assessed needs, familiar with the operational management of the centre and was aware of the centre's current status on the completion of outstanding works. The person in charge visited each house within the centre on a daily basis and residents and staff were found to be very familiar with her. The person in charge informed the inspector that she was currently in the process of establishing an office base in one of the houses to increase her presence and oversight of the centre. The person in charge also informed the inspector that she was further supported in her role through the recent appointment of an assistant director of nursing to the service, and said this has greatly supported her and enhanced the overall governance arrangements of the centre.

Meetings were held regularly between staff and the person in charge, minutes of these meetings were available for the inspector to review. The person in charge had routine meetings in place with staff nurses who offered remote nursing support to the centre. Management meetings were also held for the service each week, which the person in charge told the inspector informed her own practice in the management of the centre. The person in charge was found to be suitably qualified and experienced for the role; however, adequate garda vetting was not in place for her. During the course of the inspection, the provider did inform the inspector that this has been escalated within the service to ensure adequate completed garda vetting is secured for the person in charge.

An annual review of the centre was completed in September 2016 and the provider had conducted the most recent unannounced visit of the centre in April 2017. The centre had action plans in place, based on the findings of non-compliance identified during six unannounced visits, annual reviews, HIQA action plans and fire compliance assessment reports. However, a review of these action plans by the inspector demonstrated poor adherence to timeframes for the completion of actions. For example, of the 33 actions identified in the 2016 annual review, 15 of these actions were overdue. This was brought to the attention of the person in charge who informed the inspector that she was aware that actions were overdue, and that the purpose of the most recent unannounced provider visit was bring these overdue actions back into measurable timeframes. However, there was no structured or systemic governance arrangement in

place to support the oversight and management of the centre's progression towards future deadline achievement.

**Judgment:**

Non Compliant - Major

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

Actions required from the centre's previous inspection were satisfactorily completed. However, further actions were required upon this inspection in relation to the maintenance of Schedule 2 documents and rosters.

There were planned and actual two rosters in place for the centre. On the day of the inspection, the inspector noted there were gaps in some rosters to clearly identify what staff were on duty in the centre. In addition, some rosters did not identify the month they referred to.

Agency staff were frequently allocated to the centre and the inspector noted that the same agency staff were consistently allocated to the centre. Residents who met with the inspector were familiar with these agency staff members and told the inspector how they have been supported by these agency staff members to achieve their personal goals.

Staff supervision was in progress, with the last staff supervision meeting scheduled in the coming weeks. There was a training matrix for the centre which demonstrated staff received training and refresher training in manual handling, infection control and medication management. No gaps in staff training for these training areas were found.

The inspector reviewed a sample of staff files, which identified gaps in the maintenance of Schedule 2 documents.

**Judgment:**

Non Compliant - Moderate

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<b>Closing the Visit</b>
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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:***

Anne Marie Byrne  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

# Health Information and Quality Authority Regulation Directorate

## Action Plan



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

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0002624
<b>Date of Inspection:</b>	19 April 2017
<b>Date of response:</b>	7 June 2017

### 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 05: Social Care Needs

**Theme:** Effective Services

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

The provider failed to ensure that personal plans identified the names of those responsible for supporting residents to achieve objectives as set out in their personal goals.

**1. Action Required:**

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

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

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

The PIC has ensured that the personal plans have identified the key name of those responsible for supporting residents to achieve their personal goals.

Proposed Timescale:

COMPLETED - 28-04-2017

**Proposed Timescale:** 07/06/2017

**Theme:** Effective Services

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

The provider failed to ensure staffing arrangements were in place to support social activities where minimum staffing levels were in place

**2. 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:**

PIC has sourced additional support hours for social activities at the weekend

**Proposed Timescale:** 13/05/2017

**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:**

The provider failed to put systems in place in the centre for the management and on-going review of risk to include:

- Ensure risk assessments are reviewed in accordance with their scheduled review dates
- Provision of a smoking risk assessment which assesses residents' safety who wish to smoke
- Where appropriate, the identification of additional control measures on risk assessments to assist in the mitigation of risk

**3. 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:**

The PIC will ensure all risk assessments are reviewed and updated annually with residents PCP meeting or as required.

A smoking risk assessment has been completed which includes the residents health care and safety needs.

PIC has reviewed and updated centre's health and safety statement inclusive of risk management and identified additional control measure to address mitigation of risk.

**Proposed Timescale:** 29/05/2017**Theme:** Effective Services**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The provider failed to put in place effective fire management systems in relation to:

- Provision of adequate emergency lighting to the centre
- Adequate arrangements to ensure exits from the rear of the centre to the fire assembly point were clear at all times
- Ensuring fire procedures and personal evacuation plans guided on evacuation from upstairs accommodation
- Ensuring the fire alarm correctly identified the fire zones in the centre
- Adequate arrangements to ensure weekly fire checks were maintained

**4. Action Required:**

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

The PIC will ensure there will be adequate emergency lighting in the centre and that the fire alarm will correctly identify the fire zones in the centre by the below date

The PIC has ensured all exits from the rear of the centre to the fire assembly point are kept clear. Completed on 19-4-2017

The PIC will ensure centre's fire evacuation plan and PEEP's will reflect fire procedures and evacuation from the upstairs accommodation will be completed by 29-05-2017

The PIC will ensure weekly fire checks will be carried out, documented and maintained. Completed and ongoing

**Proposed Timescale:** 16/06/2017**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 provider failed to ensure that garda vetting was in place for the person in charge in accordance with Schedule 2 of the regulations.

**5. Action Required:**

Under Regulation 14 (5) you are required to: Obtain the information and documents specified in Schedule 2 in respect of the person in charge.

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

The provider will ensure that all the required documentation is obtained, submitted to the authority and a record held in the designated centre for the Person in Charge. The Provider has requested the outstanding schedule two documentation by writing to the HSE national department requesting that they deal with the request for this PIC's Garda vetting documentation as an urgent requirement.

**Proposed Timescale:** 30/06/2017

**Theme:** Leadership, Governance and Management

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

The provider failed to put management systems in place to ensure that the service provided is consistent and effectively monitored with regards to deadline achievements.

**6. Action Required:**

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

A new Acting Assistant Director of Nursing has been appointed with direct line management and over site responsibility for the PIC of this designated centre. A standardised set of audits to include person centred planning, medication management, hygiene and health and safety have been agreed and put into place in the designated centre to ensure that the service provided is safe, appropriate to resident's needs, consistent and effectively monitored.

**Proposed Timescale:** 10/05/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The provider failed to ensure all documents required of Schedule 2 of the regulations were maintained for all staff

**7. 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:**

The PIC will ensure all documentation as specified in the Schedule 2 will be obtained

from all staff

**Proposed Timescale:** 29/05/2017

**Theme:** Responsive Workforce

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

The provider failed to ensure the planned and actual roster for the centre showed staff on duty during the day and night at all times.

**8. Action Required:**

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

The PIC has ensured the planned and actual roster for the centre has been updated and reflects staff on duty day and night.

**Proposed Timescale:** 19/04/2017