Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Rosses View
Centre ID:	OSV-0003368
Centre county:	Sligo
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Health Service Executive
Provider Nominee:	Ann Gilmartin
Lead inspector:	Anne Marie Byrne
Support inspector(s):	Catherine Glynn
Type of inspection	Unannounced
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 March 2017 10:45	21 March 2017 21:00
22 March 2017 09:00	22 March 2017 14:50

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 the 13th 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:

Inspectors met with eleven residents, seven staff members, a clinical nurse manager and the person in charge during the inspection process. The centre comprised of six units and all units were visited by inspectors during the course of the inspection. Although inspectors met with a number of residents, residents did not communicate with inspectors. A number of practices and documents were reviewed as part of this inspection including nine residents' files, eight staff files, incident 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 is based on the HSE Cregg Services campus, located close to Sligo town. The centre comprised of six units providing residential services to people with an intellectual disability, who have been identified as requiring low to high levels of support. The service is nurse-led and can accommodate male and female residents, from the age of 18 years upwards. Four of the units provide accommodation for six residents, one of the units provides residential accommodation for five residents and one of the units provides accommodation for four residents. Two of these units provides care for residents with late stage dementia. Of the 33 residents residing in the centre, four were assessed and planned for transition into the community. There were no vacancies at the time of inspection.

The person in charge had overall responsibility for the centre and is based in the centre on a full-time basis. The person in charge held an administrative role and regularly visits each unit to meet with residents and staff. Each unit had a communal kitchen and dining area, sitting room area, bathroom facilities and bedroom spaces for residents.

Overall judgment of our findings:

This was a five outcome inspection and these outcomes related to social care needs, health, safety and risk management, safeguarding and safety management, governance and management and workforce. While the provider had made some improvements since the last inspection in September 2016, inspectors found little progress had been made to ensure adequate staffing arrangements were provided to meet the assessed social care needs of residents. Furthermore, a review of the centre's governance arrangements by inspectors demonstrated poor compliance in management's adherence to deadline achievements. Some actions from the previous inspection were not yet due, while other actions were found to be overdue at the time of this inspection.

Of the five outcomes inspected, inspectors found three outcomes to be in moderate non-compliance with the regulations and two outcomes in major non-compliance.

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):

Findings:
Overall, inspectors found improvements had been made to the assessment and planning for residents' social care needs. Since the centre's last inspection in September 2016, additional staffing support had been put in place for some residents, who required one-to-one social care support. However, inspectors found inadequate arrangements were still in place to meet the assessed social care needs of the remaining residents. Three actions were required in relation to this outcome from the centre's previous inspection report; however, at the time of this inspection, these actions were not yet due for completion. The person in charge did advise inspectors throughout the inspection of the progression made to date towards deadline achievement for these actions.

Four residents were identified for transition into the community and transition plans were in place for these residents with an estimated date for transition. Since the last inspection, a full revision of residents' needs assessments, personal plans and personal goals had been completed. Inspectors found each resident now had a comprehensive record in place, which was reviewed and maintained by staff on a regular basis. Residents were consulted during the development of their personal plans and personal goals. Documentation was found to be clear, concise and maintained to a high standard. Personal goals identified the names of those responsible for supporting residents to achieve their goals within set timeframes. However, some gaps were found in the updating of these plans to demonstrate the progression made by residents towards achieving their goals. Furthermore, copies of personal plans and personal goals were not available to residents in an accessible format, which met the communication needs of residents.

Since the last inspection of this centre, some one-to-one staffing supports were put in place, where residents were assessed as requiring this level of support, to enable residents to engage in daily social activities. Inspectors found this arrangement to be consistent and staff spoken with informed inspectors of the positive impact this had made to the quality of social care now being provided to these residents. A sample of activity records for residents receiving one-to-one support was reviewed by inspectors, these demonstrated residents were frequently attending day-care services, social events, dining out and visiting local ttractions. However, inspectors found adequate arrangements were not in place to meet the social care needs of all other residents in the centre. Inspectors observed that a large number of residents were assessed as requiring one-to-one support to engage in social activities outside of the centre. However, staff spoken with informed inspectors that adequate staffing levels and the availability of accessible transport was not consistent. Staff further informed inspectors that social activities at weekends were greatly impacted upon due to the lack of resources available to them, resulting in the majority of activities occurring within the centre. A further review of activity records by inspectors identified some residents had not been supported to engage in activities outside of the centre in over a month. The person in charge informed inspectors that a business case had been submitted for additional social care support for the centre. The outcome of this business case had not been determined at the time of inspection.

In addition, a number of residents residing in the centre had advanced cognitive impairments. These residents did not have age appropriate activity programmes available to them suitable to meet their assessed social care needs. Staff spoken with informed inspectors that they had not received training or guidance on how best to deliver social care to these residents.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
Overall, improvements were found with regards to the centre's fire safety and risk management systems. Of the nine actions required from the centre's last report, eight actions were completed, while one action was overdue.

A number of improvements had been completed since the last inspection in relation to

fire safety. The centre was now sub-divided into a number of compartments and sub-compartments for the containment of fire. Magnetic fire doors had been provided along the corridors of each unit and were connected to the centre's fire alarm system. Reader panels were provided to each unit to enable staff to quickly identify the location of a fire. Up-to-date maintenance of all emergency lighting had also recently been completed. Staff spoken with informed inspectors of the new horizontal fire evacuation procedures in place and all staff were found to have up-to-date training in fire safety. Personal emergency evacuation procedures were in place for each resident, were within their revision dates and guided on the equipment and supports required of each resident in the event of an evacuation. The centre had a review of its fire safety upgrade by a competent person in January 2017, who found these works to be satisfactory and in accordance with the regulations.

There was a system in place for the assessment, management and on-going review of organisational and residents' specific risks. Incident review meetings were conducted on a monthly basis, which generated a trending report of incidents occurring within the centre. Staff spoken with informed inspectors of their understanding of residents' specific risk assessments. In one instance, a staff member demonstrated, using a risk assessment, how the severity rating of a resident specific risk was decreased through the implementation of various control measures. Each unit had its own risk register which outlined the control and additional control measures in place; however, some inaccuracies in the identification of control measures were identified by inspectors. For example, in relation to the overall management of epilepsy in the centre, one of the control measures identified that 24 hour nursing care was being provided to residents. However, inspectors found that the night time staff nurse arrangements did not support this control measure. In addition, inspectors found some incidents where management were not responsive to the management of resident specific risks. In one instance, it was identified that some residents with neurological conditions required emergency medication to be administered to them within three minutes. However, the provider failed to ensure a satisfactory risk assessment of this risk was completed and that adequate night time control measures were put in place.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Overall, improvements were found in the management of behaviours that challenge, safeguarding of residents and in the management of restrictive practices. However, some improvements were still required with regards to providing staff with up-to-date training in the management of behaviours that challenge. Of the three actions required from the centre's last inspection report, none were yet due for completion. However, the person in charge informed inspectors throughout the inspection process of the progress being made towards completing these actions.

There were some restrictive practices in place for the use of bedrails and administration of chemical restraints. These restrictive practices were found to have risk assessments in place and were completed in a multi-disciplinary manner. Staff were knowledgeable in the appropriate use of these restrictive practices and informed inspectors that these were used as last resort measures. Staff informed inspectors that although chemical restraint was prescribed for one resident, it had not been administered for almost two years.

Where residents presented with behaviours that challenge, behaviour support plans were in place. Inspectors found these were comprehensive and informative to staff on the nature of the residents' behaviours and of the reactive and proactive interventions to be implemented. Episodes of behaviours that challenge were recorded by staff and used to inform behaviour support plan reviews. The centre had the support of a behavioural support specialist team to review and guide on the management of residents' specific behaviours. Staff informed inspectors of how they are required to support residents with behaviours that challenge on a daily basis. However, not all staff had received up-to-date training in the management of behaviours that challenge.

There were safeguarding plans in place at the time of inspection. Inspectors found evidence of preliminary screening and multi-disciplinary input into the management of these safeguarding concerns. Staff had up-to-date training in the safeguarding of vulnerable adults and were informed of safeguarding concerns within the centre. Staff recognised their responsibility in the reporting of safeguarding concerns and were aware of who these concerns were to be reported to. Safeguarding plans were found to be comprehensive and were regularly reviewed.

Judgment:
Non Compliant - Major

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

Findings:
All three actions required from the centre's last inspection report were found to be satisfactorily completed. However, inspectors found that the governance arrangements for the management of risk still required improvements in relation to deadline achievement.

The person in charge had overall responsibility for the centre and demonstrated a clear understanding of his role and legislative responsibility. The person in charge was supported in his role by a clinical nurse manager and by the provider. The person in charge was based in the centre and was available to meet with staff and residents from all units on a regular basis. At the time of inspection, management staff and nursing staff had received supervision from their line managers and a process was in place to complete supervision for all remaining staff. Staff meetings, quality improvement meetings and management meetings were occurring on a regular basis and minutes of these were available for inspectors to review.

There were a number of action plans for the centre which were maintained under the supervision of the person in charge and provider. These action plans were generated from the findings of the annual review of the service, the six monthly unannounced provider visits, the last HIQA inspection report and from the centre's own quality improvement audits. The progression of these action plans were regularly reviewed, however, upon review by inspectors it was identified that a number of these actions were overdue. For example, 29 actions were identified as part of the annual review of the service, with five actions not completed within the specified timeframes. A further three actions were overdue from the 18 actions identified within the centre's own quality improvement audit. Staff and members of management who spoke with inspectors were unclear when these action would be brought back into achievable timeframes. In addition, inspectors found repetition in the actions identified in action plans, with conflicting timeframes for completion. For example, the same action in relation to staffing resources was identified in two separate action plans, however different timeframes for completion were found in both action plans.

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:
Of the four actions required from the centre's previous inspection report, one action was not satisfactorily completed. Significant improvements continue to be required to ensure sufficient staff were working in the centre to support residents assessed social care needs. Further improvements were also required to the maintenance of Schedule 2 documents.

A training record was in place for all staff working in the centre and inspectors found staff had received up-to-date mandatory training in safeguarding, fire safety and manual handling. A sample of staff files was reviewed by inspectors and gaps were found in the maintenance of Schedule 2 documents to include gaps in employment history, references, garda vetting and evidence of identity.

A planned and actual roster was in place for all units within the centre. On-going recruitment for staff was in operation at the time of inspection and interim agency staff were being used to meet the residents assessed needs. Management staff informed inspectors that the centre had gained more consistency in the agency staff being allocated to the service, with some agency staff being provided with regular shifts in the same units. Staff spoken with informed the inspector that this consistency in agency staff has had a positive impact on residents, who are now familiar with these agency staff members. Management staff had a system in place for the induction of agency staff and informed the inspector that all efforts were being made to recruit permanent staff, in order to reduce the amount of agency cover being used by the centre.

Inspectors identified that a number of residents required high levels of support across the 24 hour day. At night time, the rostered staffing arrangement did not reflect the logistical demands and layout of the centre when meeting the needs of residents who may require urgent and immediate medical interventions for the sudden onset of epilepsy, across the six houses in the centre.

Inspectors found an overall lack of staff support at weekends resulting in residents not having the same opportunities for social engagement as they do during the week. Staff spoken with informed inspectors that there was a reduction in the staffing compliment at weekends, which meant staff could not always support residents in activities outside of the centre. Staff informed inspectors that although they are aware that personal goals have been established for residents surrounding leisure and fun, they are not always in a position to meet the actions of these goals due to the staffing resources available to

them.
Judgment: Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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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[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003368
Date of Inspection:	21 and 22 March 2017
Date of response:	13 April 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 personal plans were available in a suitable format that meets the communication needs of residents.

1. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are

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

made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
The provider will ensure all personal plans are available in a suitable format that meets the communication needs of all residents by the below date.

Proposed Timescale: 05/05/2017

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 personal plans were updated to reflect residents' progression towards achieving their personal goals.

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

Please state the actions you have taken or are planning to take:
The PIC will ensure all Personal Plans will be updated to reflect the progression made by residents towards achieving their personal goals. Staff will ensure that the personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments. Weekly audits by managers will ensure compliance.

Proposed Timescale: 30/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure arrangements were in place to meet the assessed social care needs of residents to include:
- Adequate arrangements to meet the social care needs of residents requiring additional staff support to engage in social activities
- Adequate transport arrangements
- Adequate arrangements to meet the social care needs of residents with cognitive impairments.

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:

To ensure the residents social care need are met an additional 48 hours social care support will commence for all residents in Rosses View by the 14th April 2017.

The PIC will ensure an evaluation of the participation of residents in social activities will be conducted on an individual basis over a six week period and this will be reflected in the residents personal plans. Ongoing review in relation to the effectiveness of the 48 additional hours will take place and consideration given for further hours if required, decision will be made on this as per timescale below

Adequate transport facilities will be in place by the below date.

Proposed Timescale: 26/05/2017

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 ensure adequate systems were in place for the management and review of on-going risks associated with:
- Adequate arrangements for residents who require emergency medication within prescribed timeframes
- Accuracy in the identification and recording within risk registers of control measures and additional control measures in place for epilepsy management within the centre.

4. 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 has ensured that there is a very clear protocol in place guiding staff on the procedure to follow ensuring residents who require emergency medication receive same within prescribed timeframes. Risk assessments and Risk Register are updated and include clear identification and recording of control measures and additional control measures in place for epilepsy management within the centre.

The staff nurse is now based within this unit during the night hours to facilitate the administration of emergency medication if required. An alarm system for responding to emergencies is also in place for all staff. Approval has being granted for the recruitment of an additional nurse at night.

Proposed Timescale: 30/04/2017

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:
The provider failed to ensure staff had received up-to-date training in the management of behaviours that challenge.

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

Please state the actions you have taken or are planning to take:
The PIC will ensure all staff will have received up to date training in behaviours that challenge by the below date.

Proposed Timescale: 30/04/2017

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 put in place management systems to ensure the service provided was effectively monitored in relation to deadline achievement.

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:
The Provider has assured that a clearly defined management structure for the designated centre has been identified which will reduce the current PIC's areas of responsibility. This will be operationalised by the below date. This new management structure will be resposonsible for the monitoring and management of all deadline achievements.

Proposed Timescale: 19/05/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The provider failed to ensure that the number of staff working in the centre was appropriate to the number and assessed needs of the residents in relation to:
- Appropriate number of staff to meet the social care needs of residents
- Appropriate number of staff to meet the immediate healthcare needs of residents at night

7. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
To ensure the residents social care need are met an additional 48 hours social care support will commence for all residents in Rosses View by the 14th April 2017.

The PIC will ensure an evaluation of the participation of residents in social activities will be conducted on an individual basis over a six week period and this will be reflected in the residents personal plans. Ongoing review in relation to the effectiveness of the 48 additional hours will take place and consideration given for further hours if required. Decision will be made on this as per timescale below

Approval has being granted for the recruitment of an additional nurse at night to ensure the immediate healthcare needs of residents are met.

Proposed Timescale: 26/05/2017

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 all information outlined in Schedule 2 of the regulations was maintained for all staff working in the centre.

8. 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 information and documents as specified in Schedule 2 will be obtained for all staff working within the designated centre by the below date.

Proposed Timescale: 31/05/2017