

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Rosses View
<b>Centre ID:</b>	OSV-0003368
<b>Centre county:</b>	Sligo
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Teresa Dykes
<b>Lead inspector:</b>	Thelma O'Neill
<b>Support inspector(s):</b>	Catherine Glynn; Niall Whelton
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	35
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
21 September 2016 14:30	21 September 2016 21:30
23 September 2016 10:30	23 September 2016 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

This was the seventh inspection of this centre by the Health Information and Quality Authority (HIQA). This inspection was a follow up registration inspection to assess on-going compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and to assess if the actions from the previous inspection had also been completed.

At the last inspection nine actions of concern were identified. The provider was requested to submit an action plan outlining how they would address the outstanding issues and bring the centre into compliance. This inspection focused on the providers' response to the previous action plan. During the inspection it was found that none of the actions had been addressed. Further failings were also identified.

How we gather our evidence:

Inspectors met with most of the residents, staff members and the management team during this inspection. Inspectors observed staff members attending to residents needs in a kind and caring manner. Some residents spoke kindly of staff and said that they were happy living in the centre. Inspectors observed practices and reviewed documentation including care plans, medical records, accident and incident reports, policies and procedures and staff files.

Description of the service:

This centre is one of four designated centres in a large congregated setting run by the Health Services Executive (HSE). It is located approximately five kilometers from the town of Sligo on a large site and provides residential accommodation for 35 residents with an intellectual disability. The centre consisted of four units each with six residents, two units each with five residents and one resident living in one apartment

A director of services had overall responsibility for this service and they reported to the provider. A person in charge (PIC) was responsible for the day-to-day management of the seven units in this centre. The person in charge also held the role of the assistant director of services and was responsible for the day-to-day management of the campus in the absence of the director of services. A team of clinical nurse managers were responsible for management of the individual units.

Overall judgment of our findings:

Fire safety risks had consistently been identified in this centre. The provider had given assurances that these risks would be addressed by May 2016. However, on this inspection risks previously identified had not been addressed and fire safety continued to be a significant concern. To that effect three immediate actions were issued to the Provider as detailed further under Outcome 7.

Overall the designated centre continued to be in non compliance with the Regulations. Inspectors found the provider had failed to address the nine actions previously identified. Furthermore, where areas of improvement had previously been identified at the time of the last inspection, on this inspection it was found that these improvements had not been sustained and further failings were identified. For example, the provision of day services, social opportunities and staffing provisions had all declined which was found to impact residents negatively.

Failings were identified in relation to the governance and management of the centre. Inspectors found limited oversight and accountability for aspects of service provision to ensure the service provided was safe and effective to meet the residents' needs. Staffing shortages and inconsistency in staffing was identified as a significant risk in the centre and the centre was heavily reliant on agency staff.

Inspectors also found that staff recruitment practices were inadequate as the provider had not ensured that all staff records required under schedule two of the Care and Support Regulations 2013 were present. For example, 19 staff members did not have the required Garda vetting documentation completed.

Residents did not have therapeutic intervention available on a day-to-day basis. Daily activities were not provided consistently in the centre as requested by residents and social activities were also limited due to staffing shortages and transport issues. This resulted in a lack of a meaningful day for residents.

There was a general lack of maintenance or structural improvements evident in some areas of the centre. For example, although there was access to cookers in the day service areas for use at weekends and evenings for the provision of a hot meal, cooking facilities continued to be unavailable to residents in four of the units in the centre.

These findings are discussed further in the report and included in the reports Action Plan. Where previous actions were not addressed they have been restated in 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 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

There was one action from the last inspection. This related to support provided to residents' access to manage their personal finances. This action was not addressed.

Following the last inspection the provider agreed in their action plan response that by the 30 June 2016, processes would be in place to support residents to have access and control of their own money.

The provider stated this action would be achieved by:

- Providing training to all staff in relation to managing residents' finances.
- Communication workshops for residents would be facilitated by the Speech and Language Therapist.
- An easy read leaflet on how residents could manage their own finances would be made available to each resident.
- Consultation with financial institutions was ongoing regarding opening individualised accounts for each resident in their own name.
- Financial competency templates were being trialled with residents to identify their understanding of managing their own money.

None of these actions were completed.

At the last inspection inspectors had found that management had taken action to support residents to exercise choice in accordance with their preferences and to maximise their independence. However, on this inspection the inspectors found that

these improvements, particularly in social activities, had deteriorated and residents' day activities were limited or non-existent due to staff shortages.

Although residents had personal plans in place, inspectors found residents were not fully consulted with, or did not participate in decisions about their care or in the organisation of the centre. For example, residents' social goals or day-to-day activities were often changed or cancelled at short notice due to staffing issues. Residents were not consulted or offered alternative arrangements

Transitional planning has been on-going since 2015 in this centre with eight residents at the time of inspection being identified for transition to the community. However, following a review of the residents' notes the level of consultation or participation the residents had with regards to transitional meetings was unclear.

In July 2016 the annual quality and safety report for this centre identified that advocacy services were limited, due to resource issues, and were only prioritised according to need. The inspector found that residents did not have access to advocacy services to act on their behalf, and to support them as part of the transitional process. It was also unclear whether family members were involved in the decision making process for transitions. Residents' preferences such as where they would like to live, or with whom they would choose to live with, were also not clearly identified in their transitional plans.

During the inspection, inspectors observed staff promoting residents' privacy and dignity. However, although there were locks on residents' bedroom doors, residents did not have access to keys to secure their bedrooms.

Staff members ensured residents had privacy when communicating with relatives and friends either by phone or in person. There was private space available in the centre for residents to meet family or friends. Inspectors were also told visiting times were unrestricted and family and friends were welcome to visit the centre as per residents and family wishes.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

One action was issued following the last inspection and this was found to not be completed. Although residents were supported by staff to communicate in the centre, further improvements were identified.

From a review of sample residents' personal plans the inspectors found that, communication systems were not consistently in place ensuring resident's individual needs were met. For example, in three files viewed, there was no communication assessment or communication passport available to assist residents communicate with unfamiliar people.

One resident's behaviour support plans identified that communication difficulties was a factor in behavioural outbursts occurring. However, there was an absence of an individualised communication assessment by an appropriate member of the multidisciplinary team.

Inspectors found that the majority of residents were not assessed by an appropriate specialist and also did not have access to electronic communication aids. This was an action from the last inspection that had not been completed.

**Judgment:**

Non Compliant - Moderate

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

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**

Effective Services

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

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

**Findings:**

There were two actions issued following the last inspection. These related to contracts of care and inappropriate admissions to the centre. These actions were due to be addressed by 30 June 2016, However, inspectors found that these actions had not been completed on the day of inspection.

Following the last inspection the provider advised HIQA that all residents would have a signed contract of care pertaining to their residential placements. On review, the inspectors found this action had not been completed.

The second action previously issued to the provider related to an inappropriate



emergency admission to the centre in 2015. The provider had advised HIQA that this would be prioritised and a resident would be relocated to a suitable community residence to meet their individual needs. However, at the time of inspection this had not occurred and the action is therefore also repeated in the action plan at the end.

**Judgment:**

Non Compliant - Major

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found the social care provided to residents in this centre did not reflect the assessed needs of the residents or the individualised personal goals identified in residents' personal plans.

Each resident had social goals identified, and although some goals were achieved, many were not and the assessed goals were not documented in a manner that was easily reviewed.

At the previous inspection, inspectors had found improvement in the social activities for residents. A day service previously closed had been re-opened and two staff had been allocated full-time to the service to provide a sessional day activity programme for up to 19 residents.

On this inspection the inspectors found the previous improvements in social care following the last inspection were not sustained. Although the service was scheduled to provide a part-time rotational service to 19 residents. The social activities programme was no longer operational on a regular basis or in a consistent manner that met the needs and wishes of residents. For example, inspectors found the service was only opened 14 days in August 2016 and nine days in the month of July 2016. This resulted in residents remaining on the units with no meaningful activities being offered and limited opportunities to engage in social interaction.

On the day of the inspection many residents were observed sitting in chairs in the sitting room with very little positive interaction with other residents or staff.

Some residents were supported by staff to go for walks on the campus, but a review of some residents' files showed that some residents had not left the complex recently. This was attributed to staff shortages and transport issues. In one resident's file, reviewed records showed they had attended three social outings over one month period. Two of which were for medical appointments and one was for a cup of tea in a coffee shop.

The inspectors also found that social goals for some residents were not achieved and had not been reviewed in the past year. For example, a resident had four goals identified, the date these were to be achieved by was February 2016 and were not complete.

At the last inspection, inspectors were told that annual medical reviews for residents were on-going. On this inspection, inspectors found that residents were not receiving annual medical checks as required by the regulations and some residents had not had preventative checks since 2011.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

This centre was located in a large congregated setting situated in the main campus building and comprised seven separate units. As previously identified the premises did not meet the needs of all residents and significant improvement works in the internal and external premise were required. Inspectors acknowledge that major structural works had not commenced as there was work in progress in terms of transitioning some residents from this centre to the community in the near future.

Inspectors found that the design, layout and facilities continued to not meet the individualised needs of the residents, or the philosophy of care identified in the centres Statement of Purpose.

The lack of facilities at the premises resulted in institutional practices such as the use of a centralised kitchen. Four units did not have operational kitchens. They had no cookers or hotplates to cook residents' meals or evening teas, and residents' food was supplied from the main kitchen area. The installation of cookers was an action plan response from the provider following the last inspection and this had not been addressed.

The main kitchen and restaurant closed at 15:00pm at weekends and residents were only offered a choice of a cold salad or sandwiches. Alternatively they could purchase a takeaway on those evenings. While staff stated that some residents utilised the kitchen in the day service area to cook their teas, this was not always used consistently by all residents. This resulted in residents' choice of food being limited and not having the option of a hot evening meal.

Some living rooms were comfortable and maintained to a good standard while other sitting rooms had the appearance of large institutional rooms that lacked character and decoration. During the last inspection, inspectors were told one large room was going to be divided and used to facilitate social activities for up to 12 residents. However, on this inspection the inspectors saw that while the room had been divided into two, the rooms were not decorated or furnished and residents did not have access to these facilities.

Some units did not have appropriate facilities to support individuals personal hygiene. For example, in two units, there was only one shower and one toilet for six residents. This impacted on residents' access to toileting and showering facilities. This was an action from the last inspection that was not addressed. Furthermore, residents clothes were laundered in a centralised laundry on the campus, this limited residents choice to participate in laundering their own clothes.

The locations of two sluicing machines in two units were identified as inappropriate and an infection control risk at the last inspection. Following this, the provider stated that they would relocate the machines to a more appropriate location. The inspectors found on this inspection that one of the sluicing machines was not moved and the other sluice machine was moved into another inappropriate location. The sluicing machine was moved to a utility room but posed another infection control risk. The room was used for both sluicing purposes and for laundry. Inspectors observed residents' clothes folded on top of two sinks, blocking staffs access to wash their hands.

**Judgment:**  
Non Compliant - Major

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

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

**Theme:**  
Effective Services

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

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

**Findings:**

The management of health and safety and risks in this centre was reviewed. Significant risks were identified. Individual and organisational risks were documented, however not managed in a manner that safeguarded residents and staff. These related to risks such as, fire, physical aggression, risks of residents choking, and influenza outbreaks and staffing.

There was a risk management policy and procedure in place however, it was not appropriately implemented in practice. Although resident's individual risks were assessed and risk rated, control measures were not implemented which resulted in risks not being reduced. For example, residents' behaviour support plans identified a requirement for one-to-one staffing but this resource was not consistently provided.

Organisational risks were identified on the centre risk register. Risks such as, fire risks, physical aggression, risks of residents choking, and influenza outbreaks were all rated as high risk. The inspector found the measures in place did not adequately manage the risks. For example, in one unit a delay in care and supervision to residents (due to the lack of support staff available in the unit) was identified as a high risk. However, no action to eliminate the risk was taken. The inspector also found that the control measures identified to manage healthcare associated infections did not meet the standards for the prevention and control of healthcare associated infections. For example, staff did not have training in hand hygiene.

The quality and safety risk review group (which comprised of managers and multidisciplinary team members) met monthly to review accidents and incidents and the risks associated with the centre. However, there was no evidence that this team had reviewed the accidents or incidents that had occurred in the centre. It was unclear how learning, to prevent the reoccurrence of such accidents and incidents was identified and implemented.

Improvements were required in relation to fire management at the centre. The actions with regard to fire precautions from the previous inspection were largely not addressed. The completion date for this action, submitted by the provider was 30 May 2016.

The inspector found the fire precautions in the designated centre were inadequate. To this end, three immediate actions were issued to the provider with respect to fire safety training, upgrading work to the fire detection and alarm system and the provision of appropriate fire rated door sets to provide an adequate means of escape and to prevent the spread of fire and smoke between compartments.

The person in charge, subsequently submitted to HIQA, confirmation that fire safety training was completed for all staff, the work to the fire detection and alarm system was complete (awaiting certification to be submitted) and that the work being carried out on the fire doors was in progress.

The inspectors reviewed a fire safety risk assessment report, dated March 2015, which had been completed by an external fire safety consultant. The report identified a number of risks and proposed control measures to mitigate same. Inspectors found that the provider had carried out some minor works such as filling in the recessed mat wells at exits and fitting electromagnetic door locks, to some final exits. However, overall, little progress had been made in implementing the fire consultant's recommended remedial actions.

The majority of risk items identified in the consultant's report had not been addressed. This included the replacement of doors throughout the centre with fire rated doorsets. It was difficult to determine any fire resistance of many of the doors throughout the centre. Most doors were not fitted with cold smoke seals, intumescent strips or self-closing devices which would be required to prevent the spread of fire and smoke. The inspector found that fire doors were provided in limited areas, however at the time of inspection, some doors were observed to have been held open with furniture. New fire doors, which provided an alternative escape routes from a dining area, did not have self-closing devices.

The inspector saw a drawing which identified proposed works, set out in a phased basis. The inspector was informed by the person in charge that the proposed works had been scaled back significantly. The inspector requested information regarding the revised extent of proposed works. This information was not furnished to the inspector.

The building was not adequately subdivided to prevent the spread of fire and smoke. The inspector identified the requirement for additional sub-compartmentation in order to reduce travel distance within units, to a place of relative safety. There were instances where the construction provided between existing compartments was inadequate. For example, there was a fire rated doorset located centrally below a light well, allowing smoke to pass freely between compartments. The inspector also identified numerous instances where fire hazard rooms such as store rooms and small laundry rooms were not adequately separated from escape routes with fire resistant construction.

The building was provided with emergency lighting, firefighting equipment and a fire detection and alarm system. However, the servicing records for the fire detection and alarm system and the emergency lighting system included recommendations for the systems to be upgraded due to their age. In addition, the fire safety risk assessment report identified that the emergency lighting system required a full system check to determine illumination levels throughout.

The fire detection and alarm system included one main panel serving the entire building and this was located in the vicinity of the main entrance and reception. It was identified in the fire consultant's fire risk assessment that repeater panels should be provided within each staff base.

The inspector found that the proximity of the fire alarm panel from each unit in the designated centre would result in significant delays in identifying where a fire has started, thus impacting negatively on evacuation times.

The system did not have the coverage in line with category L1 type fire detection and alarm system, which would be required in a building of this type. The coverage provided by the fire detection and alarm system did not extend to a number of rooms such as sensory rooms and a small laundry room

There was a multi-sensory room which was equipped with projectors and lighting equipment. This was an inner room. The inspectors found this room to be locked with equipment powered on and unattended. This room was not fitted with smoke detection. This was brought to the attention of the provider, who confirmed the room would be put out of service until upgrading works were carried out to the fire detection and alarm system.

The inspector was not assured that a robust fire safety management system for evacuation procedures and on-going maintenance of fire safety systems were provided at the centre.

There were fire procedures in place within each unit in the building. The procedures were displayed in both written and drawing format. Some drawings throughout the centre portrayed future proposed works including lines of compartmentation that did not yet exist. This may lead residents to be evacuated to areas which would not be adequately separated from the location of a fire with fire resistant construction.

Evacuation drills were being carried out in each unit twice monthly, with one occurring during the day and one at night. The inspector found that the drills were not adequately simulating real life night time conditions. The inspector saw the report for one drill, where all residents were in bed. The duration of this drill was excessive at ten minutes. Due to the lack of sub-compartmentation, some units were conducting joint drills with the adjacent unit. This was not the case in all units. Although the frequency of drills is considered good practice, records indicated that the drills in some cases were of excessive duration. There were instances where residents were distressed or were reluctant to leave during the drill and their evacuation was simulated, without identifying alternative methods of reassuring the resident.

The inspector spoke with staff in one unit, who indicated that typically, two staff members would be on duty at night covering two units. In one of the units the nurse on duty would relocate to another unit to administer medication, leaving one member of staff covering two units. After looking at records for the drills and feedback from staff, the inspector was not assured that the plans and practices in place, including staffing levels, were sufficient to ensure a timely evacuation.

The inspector found that the needs of residents in the event of a fire were assessed by way of Personal Emergency Evacuation Plans (PEEPs), which formed part of each resident's care plan. There was also a 'quick evacuation plan' on display in each unit which contained synopsis evacuation information for each resident. The PEEPs were found to be sufficiently detailed and addressed the methods of evacuation for both day and night time scenarios. However, inspectors noted that PEEPs for some residents had not been reviewed since January 2015.

In the main, residents were not provided with adequate means of escape. Records from drills and conversations with staff members indicated that there were occasions where the escape routes taken were not through defined escape routes, but through a day room or dining room. Ramps provided outside final exits, forming part of the means of escape, were found to be excessively steep and difficult to negotiate. For example, one ramp was found to have a gradient of approximately 1:4, which is far in excess of the maximum recommended gradient of 1:12. Other external escape routes were found to

be obstructed with plant pots.

The inspector noted a resident's room which was located along the same corridor as the commercial kitchen and laundry room. The sub-dividing doors along this corridor were not capable of restricting the spread of fire and smoke through the building, therefore putting this resident at additional risk.

The inspector looked at laundry facilities in the centre. There were small laundry rooms dispersed throughout the units. The inspector noted there were no adequate checks in place to prevent the accumulation of lint in these clothes dryers. One dryer was noted to have a lint tray which had not been emptied and another was found to be damaged. This was brought to the attention of the person in charge. The inspector looked at the large commercial laundry room and found that the doors did not appear to be fire doors.

The main kitchen was fitted with a roller shutter door separating it from the main corridor area. However, the inspector spoke to staff and the person in charge and it was not clear, that the roller shutter door was fire rated and what, if anything, triggered the roller shutter door to shut in the event of a fire. There was a deep fat fryer in the kitchen, however an automatic fire suppression system was not provided.

The provider had made arrangements for fire safety training to be provided to staff. However, documentation available to inspectors indicated that a significant number of staff had not received training within the previous 12 months. Documentation relating to fire was held separately within each unit in a fire safety folder. This included a fire safety register which was not being filled out. Inspectors saw monthly health and safety checklists which included some of the fire safety systems in the centre and daily checklist for exits, extinguishers and exit signs. The checks were not of adequate detail or frequency to ensure all fire safety features were functioning correctly. For example, the inspector did not see any log of weekly checks for the alarm system or daily checks of the fire alarm panel. Inspectors spoke to staff within each unit and found them to be knowledgeable of fire safety and what to do in the event of a fire. However, the procedures relayed to the inspector from staff were at variance in some units.

**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:**

Measures to protect residents being harmed or suffering abuse were not in place, and appropriate action to protect residents was not being taken. Improvements were required as not all staff had Garda vetting. Additional improvements were also required regarding behaviours that challenge.

There were policies and procedures in place to manage safeguarding risks in the centre. These were followed in response to allegations, disclosures or suspected abuse. Inspectors observed the policy and procedures in place for the prevention, detection and response to abuse and this policy was accessible in each unit in this centre, staff were also familiar with these policies.

There was a designated safeguarding team available to support the residents and staff in this centre. The designated person for this centre was the person in charge. They advised the inspectors that they had conducted some preliminary screenings on safeguarding, which were closed at the time of this inspection.

Training in relation to safeguarding was available to all staff in the service however, eight staff did not have up-to-date safeguarding training and two of those staff had no Garda vetting clearance. Furthermore, another 17 staff working in the centre did not have Garda clearance and one staff member refused to attend safeguarding training.

There was a policy in place for the provision of managing behaviours that challenge. Specialist and therapeutic interventions were implemented in consultation with members of the multidisciplinary team, such as the General Practitioner (GP), psychiatrist, psychologist, and the clinical nurse specialist in behaviour. Interventions were reviewed as part of residents' personal planning process to assess their effectiveness

Inspectors found although restrictive procedures were monitored there were no formal reviews of its use, with the aim to prevent restrictions being used or to prevent restrictions from being overused. For example, the use of locked doors, sleep systems and bedrails had not been reviewed in line with best practice.

Inspectors also found that medication to manage behaviour's that challenge was regularly used for some residents. Although the use of p.r.n medication (medication used as required) was recorded, there were no clear protocols or guidance in place to ensure that a consistent approach was taken when administering p.r.n medication. In addition, appropriate reviews were not taken following administration of p.r.n medication. For example, one resident was administered a p.r.n sedative nine times in one month and on seven of these occasions this was administered by night staff. Night staff had frequently recorded that behaviour support distraction techniques were ineffective and p.r.n was warranted. However, no review of the behaviour support plan was conducted to ensure that it was effective, or that the p.r.n medication was administered as recommended by the psychiatrist.



Staff had not received training in managing behaviours that challenge.

**Judgment:**

Non Compliant - Major

**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):**

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

**Findings:**

There was one action issued following the last inspection. This action was not addressed. Residents' general welfare and development needs were reviewed. However, individually assessed plans were not implemented to support education and training. In addition, some residents had not been provided access to their local community. The provider had given assurances in their previous action plan response that these issues would be addressed.

These assurances were:

1. That residents would be provided training to promote social and community integration to assist residents transitioning to the community and this was not achieved within the timeframe provided
2. A review of day services and an implementation plan would be undertaken and this would be actioned. This had not been achieved within the timeframe provided.
3. External staff would be made available to support the residents in transitioning to the community including teaching individuals cooking skills. This had not been achieved. However, six residents did attend a six week drama regarding self advocacy and a community inclusion group in June 2016.

Resident's personal goals were recorded in their "listen to me document". However, it was not clear that residents or their family members were consulted with during the development of these. Furthermore, some residents' goals were not specific and there were no clear timelines set to achieve these goals. The responsibility of who would support residents achieve their goals were also not identified. For example, one resident had identified horse-riding and swimming as their personal goals. However, these activities had not taken place and there was no record why they the goals were not

achieved.

Some residents attended a full-time day programme. Residents told inspectors what activities they pursued at their daily activities programme. They discussed the positive experiences and said they enjoyed meeting new people daily. However, as discussed in outcome one, day services were only operational on a sessional basis for about two hours a few days a week. This daily schedule was regularly changed or cancelled due to staffing shortages, or staff leave. This impacted on residents' day activities and there was no consistency in the service provided.

Residents that chose not to avail of sessional day services activities were not provided with alternative activities that suited their individual interests and capabilities; such as, in-house based activities, social and community activities.

**Judgment:**

Non Compliant - Major

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

There were two actions relating to this outcome issued following the last inspection. These actions were not fully addressed. These actions related to institutional practices around the provision of residents meals and the opening hours in the canteen.

Residents' acute healthcare needs were well met. Residents were individually assessed and monitored by the General Practitioner (GP). A GP attended the centre twice a week to attend to residents' medical needs. At the last inspection, inspectors were told that annual medical reviews for residents were on-going, but on this occasion, inspectors found that some residents had not received annual reviews or preventative checks by a healthcare professional since 2011.

Inspectors reviewed residents' health care plans and found them to reflect resident's individual needs and offered clear guidance to staff on how to attend to the residents' medical needs. There was good evidence that residents were referred to and reviewed by specialists where appropriate. Progress notes were completed for each resident which reported on the care provided.

Inspectors reviewed wound care management in the centre and found that there were adequate assessments and reviews of residents' wounds and appropriate input from the multi disciplinary team, such as the general practitioner, tissue viability nurse specialists, dieticians, and physiotherapists.

The management of residents' diabetic care in this centre required review, particularly in relation to the management of hyperglycaemia. Inspectors found records where residents' blood levels were high and the specific protocols in place to manage the condition had not been implemented. Furthermore, one resident was being woken at inappropriate times during the middle of the night to check their blood sugar levels. There was no protocol stating that the resident required this intervention every night. This practice unnecessarily disturbed the resident's sleep. The practice had also not been reviewed. Staff working in this centre did not have specific training in managing diabetic care despite these specific care skills being required on a daily basis by some residents.

Residents' access to appropriate kitchen facilities was not available in the centre. The inspectors found the current practices and facilities promoted institutional practice that impacted on some residents' rights. For example, a centralised kitchen continued to provide all of the meals for the residents in this service and meals were supplied to each unit at set times daily; 12.30pm and 16:30pm. This limited choice and variety available to residents regarding their meals and schedules. Residents' choice to actively engage and participate in meal preparation was limited. This was due to a lack of cooking facilities in four of the seven units. This issued had been identified on previous inspections and remained an action on this inspection.

The canteen available to all residents and staff in the campus was also situated in the building near this designated centre. It was observed to be used by several residents during the inspection; however, it continued only to operate during the hours of 09.00am to 17.00pm and closed at 15.00pm at weekends. This was an action from previous inspections that was not adequately addressed.

**Judgment:**

Non Compliant - Moderate

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

There were written operational policies relating to the safe management of medication. This included ordering, prescribing and the storage of medicines. In addition there were processes in place for the handling of medicines, including controlled drugs, safe and in accordance with current guidelines and legislation.

The prescription/administration charts for some residents were reviewed and inspectors noted that all medications were individually prescribed and regularly reviewed by the GP. Inspectors reviewed medication charts and found that medications were administered as prescribed to the resident for whom it was prescribed.

There were some medication administration practices that did not comply with medication policies and procedures as residents were not receiving their medication daily at the time prescribed. The reduction of nurses on duty from six during the day to two at night was impacting on the timely administration of night time medication. This issue was identified as a high risk on the centre's risk register and the control measures in place were not implemented to reduce the risks identified. This included training non-nursing staff to administer medication to residents. However, this was not completed.

The lack of trained staff to administer medication to residents at night resulted in a delay in the administration of medication to residents at night. As a result two nurses working at night had to leave their units to administer medication at 10.00pm in five other units for up to 24 residents. This additional task was impacting on the care provided to residents in the nurses units. For example, inspectors found that while one of the nurses left the unit, a care staff was requested to additionally supervise the five residents in the nurses care, resulting in managing the care for ten residents with high dependency needs in the two units. The risks to the residents associated with this task were highlighted to management as a high risk, but had not been addressed.

Some residents living in this centre had epilepsy and some residents were prescribed and occasionally required emergency medication. However, the staff supervising the residents' at night were not trained in administering this medication and contacted the nurse working in another unit in the campus to administer the medication. This practice put the residents at risk due to a delay in the response to administer emergency medication.

**Judgment:**

Non Compliant - Moderate

**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:**

The centre had a Statement of Purpose in place, however, it did not accurately reflect the services provided in the centre. In addition, the matters listed in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 were not all present.

The statement of purpose did not describe the facilities and services provided or reflect the diverse needs of residents.

Furthermore, the statement of purpose was not kept under review and did not reflect the increase in the capacity of units from six to seven.

**Judgment:**

Non Compliant - Moderate

**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:**

Management systems were not effective ensuring that the centre was safe and appropriately managed.

The purpose of this inspection was to confirm that on-going improvement was sustained in the centre following the last inspection and that the actions identified were appropriately implemented. Significant time was given to the provider to allow time to address all of the actions from the last inspection. However, inspectors found that no improvement had occurred and the nine actions previously identified were also not addressed. Further areas for improvement were identified.

Three immediate actions were issued on the day of inspection requiring the provider to immediately address serious fire risks identified. The provider had been aware of these risks since March 2015. The Provider had given HIQA assurances that a schedule of

works was completed and due for completion in May 2016. At the time of this inspection the work had not commenced. This resulted in continued ineffective systems in place to ensure residents were protected from the risk of fire.

Following previous inspections of this campus the provider had reconfigured the campus from one large centre to four smaller designated centres. The numbers of persons in charge increased from one to three, this had resulted in one person in charge managing the seven units in this centre.

Despite the changes in the governance of the centre, inspectors found that the previous improvements were not sustained and the written assurances provided to HIQA were not implemented within the agreed timeframes as per the provider's action plan responses. The actions outstanding from the last inspection related to fire safety issues, residents' financial competency assessments, infection control, social inclusion and transitioning residents to the community. None of the actions previously identified were addressed at the time of this inspection.

The day-to-day management of the unit was supervised by two clinical nurse managers who demonstrated an understanding of the Regulations and Standards. However, a serious number of failings in the governance and management of this centre were identified on this inspection. For example, although an annual review of the service had been completed, there were inadequate actions identified to implement the required changes to meet the Regulations. In addition, the six monthly unannounced visits by the provider or nominated person did not identify areas of concern and failed to identify a plan to address previous actions or non compliances with the regulations.

There were inadequate staff recruitment practices in the centre. The centre was dependent on agency staff to operate this centre on a daily basis and not all staff had the required mandatory training. In addition, the provider had staff working in the centre that did not have the required Garda Vetting to safeguard vulnerable adults.

Furthermore, staff were not supported to develop their knowledge or skills to meet the needs of the residents. For example, there were no support and supervision meetings held with staff to exercise their personal or professional responsibilities to improve the quality and safety of the services they were delivering.

**Judgment:**

Non Compliant - Major

**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:**

Residents had difficulty in accessing the community due to a lack of transport. There was only one wheelchair accessible bus available to the 35 residents. However, this bus was out of order at the time of inspection. Inspectors were told the bus was regularly out of order. This greatly limited residents' opportunities to leave the campus and access community services.

In one case, inspectors found that one resident had not left the campus grounds for over a month, despite social goals to go shopping in the community, to go to a hairdresser, or to go out for a meal. This was identified at the last inspection and had not been addressed.

**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:**

The number and skill mix of staff working in this centre was inadequate. The lack of consistent and familiar staffing was identified as a failing; that was not managed and this was negatively impacting daily on the operational management of the centre.

There was one action issued following the last inspection regarding staff working in the centre not having completed mandatory training. The provider gave assurances following the last inspection that all of the required mandatory staff training would be completed. This action was reviewed on this inspection and found that the required action had not been addressed.

There continued to be significant failings in relation to staff training specifically areas of mandatory training. For example, 16 staff did not have up-to-date safe moving and handling training, 32 staff did not have training in managing behaviours that challenge,

30 staff did not have hand hygiene training, eight staff did not have safeguarding training, and five staff did not have fire safety training completed. Additional training such as diabetes, infection control, and epilepsy management had not been provided to staff in line with residents' needs.

The number and skill mix of staff did not meet the assessed needs of the residents. Staffing levels in the centre was identified as an issue on previous inspections and inspectors were assured by the management team that additional staff resources were being secured. However, on this inspection inspectors found no improvements had been made and a significant amount of the current staff resources were provided by agency and relief staff. The dependency of agency staff was negatively impacting on the provision of care or social activities delivered to residents and inspectors were told that frequently the agency could not meet the demand for staff required.

Inspectors found the lack of unfamiliar and inconsistent staff working in this centre was impacting negatively on the residents. For example, agency staff were not familiar with residents' behaviour support plans, intimate care plans and social goals which resulting in negative outcomes for residents. In addition, there was no evidence of a sufficient induction to the units to ensure the residents were consistently supported. For example, on the night of the inspection a night staff came on duty had not worked in the unit for a number of months and was not familiar with the residents' current care plan and no familiarisation induction was provided to this staff member.

Staff had not received support and supervision meetings with their manager, resulting with poor oversight of staff.

**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:***

Thelma 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 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-0003368
<b>Date of Inspection:</b>	21 and 23 September 2016
<b>Date of response:</b>	13 January 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 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

Residents did not have the opportunity to participate in and consent with support to make decisions about his or her life.

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

**1. Action Required:**

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

1. "Currently individuals funds are held a local Patient Private Property Account with surplus funds held in the HSE Patient Private Property AccountS. Cregg Services is committed to the operation of the local Patient Private Property (PPP) Account in line with HSE Financial Regulations and guidelines in a manner which maximises the access of individuals to their funds. Currently each individual holds money in individual purses held in units. Additional funds can be sourced from their funds held in the local PPP account through the Accounts Office during office working hours Monday through to Friday.
2. 2 sessions regarding managing Residents finances for staff have taken place on 12th Oct & 16th Nov 2016. Further dates to be arranged from Administration & Finance in December 2016 & January 2017.
3. Easy read version in relation to residents finances has to be completed by end of January 2017.
4. Financial Competency Template is being rolled out across the service & piloted in Rosses View – Speech & Language therapist manager worked alongside the Nurse managers to complete same.
5. Communication Workshops for Residents & Staff have being completed by the Speech & Language therapist to set up a Lamh Environment in 1 area. Further communication workshops will be rolled out across Rosses View with the speech & Language therapist –to be completed by end of January 2017.
6. Workshops have taken place throught Drama re Self Advocacy & Community Inclusion in the Sligo town —this took place over a 6 week period—6 residents attended from Rosses View. This process has continued over a further 6 weeks period & evaluation of same completed on 16/11/16. Further discussions regarding clear pathway with external group in how to proceed with the next group & feedback from Residents who have already attended is to take place in January 2017. External agency are presently unable to meet the Individual needs for our residents within Rosses View following application to have an advocate appointed for each individual due to staffing constraints within their own service. contact will be made with the other groups in Sligo in order to establish an Advocacy group with the residents supported by their staff .
7. Residents are consulted at all house meetings in relation to decisions regarding the service they are currently being provided with. Their support person accompanies residents who require same.

**Proposed Timescale:** 31/01/2017**Theme:** Individualised Supports and Care**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Residents did not have access to independent advocacy service to support them in a time of transition to the community.

**2. Action Required:**

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

1. Advocacy workshops have taken place through Drama re Self Advocacy & Community Inclusion in the Model Arts Sligo —this took place over a 6 week period—6 residents attended from Rosses View. This process has continued over a further 6 weeks period & evaluation of same completed on 16/11/16. Further discussions regarding clear pathway with Inclusion Ireland in how to proceed with the next group & feedback from Residents who have already attended is to take place in January 2017.
2. Easy read version on their rights as a citizen for residents to be looked at & put in place across Rosses View, this to be done in conjunction with Inclusion Ireland & Citizens Advise Group.
3. Personal Identification Cards /Passports are to be organised with the local government offices. This has to commence across Rosses View
4. 2 Managers in the service are continuing their training in relation to being Transition officers within the service. Next training dates are 5th, 6th & 7th Dec 2016.

**Proposed Timescale:** 28/02/2017

**Theme:** Individualised Supports and Care

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

Residents' personal space and personal possessions were not secure and there were no locks on residents' bedroom doors.

**3. Action Required:**

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

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

In order to ensure that each person's personal possessions are secure, we will take the following actions:

1. All staff ensure dignity and respect for each person at all times.
2. Thumb Turns/Devices will be installed on all bedroom doors across Rosses View to ensure Privacy & Dignity is respected in relation to each person's living space, intimate & personal care & personal information.
3. Signage in place on all Bathroom & shower rooms to promote Dignity & Respect for each person.
4. 2 ladies living in Hazelwood are able to use their key to access their own bedroom.
5. Managers carry out a daily walkarounds.

6. Individual Intimate Care Plans ensure dignity, privacy and respect.

**Proposed Timescale:** 28/02/2017

**Theme:** Individualised Supports and Care

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

Residents financial competencies were not assessed to identify their understanding and ability to manage their own money.

**4. Action Required:**

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

1. The financial manager will ensure that relevant information on HSE guidelines is disseminated to all staff in Rosses View during training workshops.
2. In respect to the general contention that residents have timely access to their own funds Cregg Services is committed to the operation of Patients Private Property Accounts in line with HSE Financial Regulations and guidelines in a manner which maximises the access of residents to their funds.
3. 2 sessions regarding managing Residents finances for staff have taken place on 12th Oct & 16th Nov 2016. Further dates to be arranged from Administration & Finance in December 2016 & January 2017.
4. The financial, manager has advised that she is willing to discuss the above with HIQA Inspectors if required. Contact details will be provided on request.
5. Financial Competency Template is being rolled out across the service & piloted in Rosses View – Speech & Language therapist manager worked alongside the Nurse managers to complete same.
6. Communication Workshops for Residents & Staff have being completed by the Speech & Language therapist to set up a Lamh Environment in 1 area. Further communication workshops will be rolled out across Rosses View with the speech & Language therapist –to be completed by end of January 2017.
7. Easy read version in relation to residents finances will be completed by end of January 2017.

**Proposed Timescale:** 31/01/2017

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

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

Residents were not facilitated to access assistive technology and aids and appliances to

promote their full capabilities.

**5. Action Required:**

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

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

1. All residents have a Communication Passport in place across Rosses View & preferred Communication Style template are in each persons personnel plan identifying each residents preferred communication style. Template from SALT.
2. Each person in Rosses View has access to a computer where assistive technology programmes have been installed by the HSE IT Dept. Individual additional apps will be added to each individuals tablet.
3. 4 residents have Ipad/Tablets— which are used for social interaction, Education & a link with their families. Wifi Dongle in place for Skype in relation to 1 resident.
4. 2 Residents have Mobile Phones to have a link with their Families & Friends.
5. A number of residents have Mobilised wheelchairs so they are able to access areas of their preferences.
6. 1 resident in St Raphaels has a digital Photo frame that she uses for family memory.
7. Further exploration with Residents across Rosses View is to take place in relation to purchasing further devices if desired. This information will be ascertained from each person , with the support of their support worker, and families. The Speech & Language Therapist Manager will be support this process.

**Proposed Timescale:** 31/01/2017

**Theme:** Individualised Supports and Care

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

Communication assessments were not completed to ensure residents were supported at all times to communicate in accordance with the residents' needs and wishes.

**6. Action Required:**

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

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

1. All 33 (100%) people have Communication Assessments were completed by the Speech & Language therapist on each person in Rosses View , this ensures that each person is supported to communicate in accordance with their needs & wishes.
2. All 33 (100%) people living in the Rosses View Service have a Communication Passport in Place.
3. All 33 people have a Listen to me Document in Place.
4. New PCP Documentation is being rolled out across Rosses View at present. This is to be reviewed in 3 Months by Nurse Practice development team which incorporates all the above documents. Workshops completed on 7th & 14th November 2016. A database is

being developed and updated on a weekly basis at the Quality, Safety and Governance Monitoring Meeting.

5. Compatibility Assessments for residents in Rosses View that are due to move to Community Setting have commenced. These will be completed prior to moving from Rosses View.

6. Communication Workshops for Residents & Staff have been completed by the Speech & Language therapist to set up a LAMH Environment in 1 area. Further communication workshops will be rolled out across Rosses View with the Speech & Language therapist – to be completed by end of January 2017.

**Proposed Timescale:** 31/03/2017

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

**Theme:** Effective Services

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

Service level agreements were not fully in place for each resident.

**7. Action Required:**

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

1. The new Contracts of Care have been individualised & reviewed. The Administration & Finance department are part of this process in relation to charges for each Individual.
2. Families will receive a copy of the individualised contracts of care when all is completed by the end of January 2017.
3. Residents who have the ability will sign their own contracts of Care if they so wish.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

Planned discharges to the community by 30th June 2016 had not occurred as per previous action plan responses.

**8. Action Required:**

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

1. Rosses View are currently involved in a compatibility assessment supported by their support persons and the Speech and Language Therapy Manager. Individual goals have been identified through their individualised living options and their annual review that will support their transition into the community. They are currently undergoing their discovery process with their support person and family. The transition is scheduled for the 1st Quarter of 2017. They are currently undergoing their discovery process with their support person and
2. Other proposals to decongregate in Rosses View are for 2017 & 2018 are to be explored.
3. A number of Managers in the service are continuing their training with external agency in relation to being Transition officers within the service. This is to be completed in Dec 2016. They will be involved in incorporating this process.

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

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

Residents had not had annual health checks since 2011. Arrangements were not in place to provide annual health reviews for residents.

**9. Action Required:**

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

1. Medicals recommenced Tuesday 13th Sept 2016—medicals to be completed weekly for Rosses View.
2. Database in place with GP Practise in relation to dates when people had received their last medical. Medicals carried out in 2011 are prioritised by the GP. Plan in place to complete 3 Medicals each week in Rosses View. An agreed weekly schedule has commenced for this service – 3 people will have their medicals reviewed weekly thereafter. To date 100% of people have had their annual medicals completed St Raphael's, 60% in Hazelwood, 50 % in St Bernadette's, 66% in Innisfree. Medicals will continue with Coney View and Benbulbin View. All medicals for people in Rosses View to be completed by 31st March 2016.

**Proposed Timescale:** 31/03/2017

**Theme:** Effective Services

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

Residents were not achieving their personal goals and the effectiveness of the personal plans were not reviewed.

**10. 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:**

At the time of publication, the provider had not submitted a response to this action.

**Proposed Timescale:**

**Theme:** Effective Services

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

Effective arrangements were not in place to ensure residents' day activities and social care goals were achieved as required.

**11. 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:**

1. Each person in Rosses View has completed their Annual Review. Each person was supported to be fully involved with the process
2. Individualised personal Goals were set for each resident from their Annual Review.
3. Each person is supported to attend their Annual Review if they so wish.
4. Family review forms are forwarded to families prior to their Annual Review, some families may choose not to attend but their review forms are discussed at the review.
5. The new Personal plan incorporates an action plan for their personal goals under the following headings- social goals, educational goals, communication goals, community involvement goals, skills for independent living, health care skills, recreational skills, maintaining relationships, money management, work-employment.
6. All new documentation is on the Shared Drive for staff to access.
7. 2 training workshops have been completed for staff on the 7th & 14th Nov in relation to the updated Personal Plan process.
8. From 21st Nov 2016 Dream programme will be operational with the full complement of staff (2 full time staff) where 19 residents receive a service on a rotational basis.
9. A Business case has been submitted for replacement of 1 staff in Dream programme who is scheduled to go on Maternity leave on the 24th December 2016.
10. The Dream Programme is audited monthly on the hours that residents receive within this programme.
11. Each person's personal goal is carried through from their home to the Dream programme. In particular their community and social goals to ensure consistency and



continuity. Each person's Personal Plan will transfer with them to their day programme.  
12. The Dream programme is audited and reviewed monthly to ensure that each person accessing the Dream programme is supported to work towards achieving their personal goals.

**Proposed Timescale:** 31/03/2017

### **Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

1. There were inadequate private and communal facilities to promote residents' privacy, choice and dignity.
2. The individualised kitchens did not have cooking facilities, or kitchen equipment to promote independence and choice for residents.
3. Arrangements for sluicing in the centre were not suitable.
4. Facilities for residents to launder their own clothes were not adequate or safe.
5. There were inadequate toileting, showering and facilities to meet residents' needs.

#### **12. 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:**

A full review of all actions required to achieve compliance was completed. The following specific actions have been initiated and these will be completed by 31st January 2016

1. Fire Works are ongoing at present where Fire Doors are being Installed, Emergency Lighting is being completed, exit lighting & Fire Repeater panels are completed in the 6 areas. All work commenced in September 2017.
2. At the present time all compartment door are in position and hung on all units within the main building. The emergency lighting and running man signs are in place and working. The free swing closers and magnetic devices have been installed just waiting connection.
3. A painter is presently on site painting of New Doors. Painted to be extended across Rosses View following construction works.
4. On completion of the Fire Works, 3 cookers will be installed into the following areas – Innisfree, St Bernadettes & Hazelwood.
5. Folding of Clothes in St Raphaels are presently being completed in an unoccupied room.
6. 1 Room in Coney View/ Benbulbin View will be completed: Furniture & accessories are identified & ordered, when major constructal fire works is completed this room will be furnished & completed.
7. Sluice Machine to be relocated from existing area in Benbulbin View to a new identified area. This will create another toilet within this area. This action will be completed by an external contractor by 28th February – quotations x 3 are being

sourced.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

1. The design and layout of this centre was inadequate and did not meet the assessed needs of the residents.
2. The premises were not kept in a good state of repair externally.
3. The premises required significant amount of decorative works.

**13. Action Required:**

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

1. Fire Works are ongoing at present where Fire Doors are being Installed, Emergency Lighting is being completed, exit lighting & Fire Repeater panels are completed in the 6 areas. All work commenced in September 2017.
2. At the present time all compartment door are in position and hung on all units within the main building. The emergency lighting and running man signs are in place and working. The free swing closers and magnetic devices have been installed just waiting connection.
3. A painter is presently on site painting New Doors. Painted to be extended across Rosses View following construction works.
4. On completion of the Fire Works, 3 cookers will be installed into the following areas – Innisfree, St Bernadettes & Hazelwood.
5. 1 Room in Coney View/ Benbulbin View will be completed end of February 2017. Furniture & accessories is presently being identified & ordered, when major constructal fire works is completed this room will be furnished & completed.
6. Sluice Machine to be relocated from existing area in Benbulbin View to a new identified area. This will create another toilet within this area.
7. Folding of Clothes in St Raphaels are presently being completed in an unoccupied room.

**Proposed Timescale:** 31/01/2017

**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 control measures and actions required to manage on-going risks identified in the

centres risk register were not complete.

#### **14. Action Required:**

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

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

1. All Risk Registers are reviewed on a Monthly Basis and additional control measures put in place become existing controls and Risk rating is reviewed according to this process. September October November & December risk registers are reviewed & updated and a number of risk ratings reduced .-Fire, Influenza & physical aggression.
2. All outstanding risks not managed on local register are forwarded to main risk register in HSE CHO area 1.
3. The Incident review Group meet on a Monthly basis to review all incidents. Learning from incidents are completed and managers receive same to discuss with their team. Discussion with team managers in relation to learning process is documented at team meetings each month.
4. Lead on Positive behaviour support Plans is Dr in psychology & supported by CNSs in behavioural needs. Positive behavioural support plans in place for residents & updated at MDT meetings or as required. Restrictive practise committee in place led by Psychology Dept also & supported by Psychology Assistants, Clinical Nurse Specialist in Behaviours, Director of Services & Service Area Manager.
5. 1:1 staffing in place in areas of concern to reduce the risk & promote a culture of safety for all. Structured programme in place in Day services for residents to meet their will & preferences. Dream has its full compliment of 2 wtes.
6. All residents have a Person Centred Plan to promote their will & preference & person centredness to reduce any aspect in risk management along with individual risk assessments. New PCPs will be completed in the area, to date a number of new PCPs are in operation to guide the personal needs of the Individuals.
7. All staff requiring Studio 111 training will be completed in this centre to enhance the quality of life for residents who require positive behaviour support plans.

#### **Infection Control**

1. Hand Hygiene training plan of dates is in place for Training for staff, within Rosses View we have 1 Staff Nurse who is a "champion" in infection control. All staff will have Hand Hygiene training by end of January 2017. Infection Control Specialist is.
2. All Individuals have received the Flu Vaccination across this designated centre.
3. Policy & Procedure in place in relation to guidelines in the event of any outbreaks of Influenza which is followed by staff, Infection Control & Public Health are contacted & Isolation protocols followed as required.
4. Medicals completed on all Individuals across this designated centre.
5. GP contract with service in place – Bi-weekly clinics & on call arrangements outside of this service.
6. Environmental Health Audits are completed in areas on a monthly basis & information returned to Clinical Nurse Specialist in this area & all recorded on performance indicators.
7. Housekeeping staff in place across this designated centre & deep cleaning carried out following any isolation outbreak in relation to Influenza or any other viruses.

## Nutritional

1. All Individuals have a risk assessment in place in relation to Mealtimes Issues & risks regarding episodes of choking. Risk registered has this risk within.
2. Algorithm in place in to direct staff to deal with any episode of Choking incidents. All incidents are reviewed immediately if any episode of choking occurs by MDT & appropriate measures put in place.
3. All referrals for any additional requirements is completed.
4. Mealtime guidelines in place for Individuals who require this —the lead in this area is Speech & Language Therapist Manager. Texture of meals are guided by these guidelines & appropriate meals are presented for individuals depending on texture required. Texture "C" meals are provide by external company which was directed by Dietician.
5. Policy & Guidelines in place for this area & national guidelines on thickening of Fluids followed.
6. CPR & FEDs training completed by Staff in designated centre.
7. All Individuals are seen by the Dietician in relation to mealtime guidelines.
8. Audits are carried out by the manager in the area in relation to meal time guidelines on a monthly basis.
9. All Mealtime Guidelines are reviewed by Speech & Language therapist manager on a regular basis.

## Staffing

1. Staff Rosters are in place across this designated centre.
2. Additional staffing has being assigned to the Dream Programme where we have 2 wte in place.
3. Night Time staffing attached to the units has a number of Staff nurses who are required to cover areas for medications—When staff are away from unit & if an emergency arises we have an Alarm Sytem in place for this & also Senior Cover manager is on campus to attend to emergency.
4. In the event of fire Evacuation at night - Fire Procedures are in place in relation to Protocol & what staff members helps out in each area.
5. Fire Risk Card updated by Fire Service in 2016 in relation to all aspects of residents dependency level in 2016. Fire Service are 7 Minutes from Cregg Campus.

## Fire.

1. The Rosses residential centre has been sub-divided into eight (8) No. compartments and six (6) No. sub-compartments ensuring that no more than 3-5 residents are located within each sub-compartment in accordance with the principles indicated within Technical Guidance Document B and relevant section of Health Technical Memorandum. Four (4) No. refuge areas enclosed in 60 minute fire resting construction including new FD60s door sets (two (2) in each ward area), have been provided in accordance with best practices.
2. All Fire Safety upgrade works on-site are complete and were supervised by external company who were assigned by HSE to carry out works in Cregg Services. The works were carried out in accordance with SI 367 of 2013. ( See Report attached)
3. Additional Fire Training in the evacuation process will be discussed with external provider & Fire Officer HSE in relation to additional training re- evacuation with all Fire Doors . Training taken place on 13/1/2017.

4. Monthly Fire Drills are continuing on both Day & Night Duty. Deep Sleep evacuations have been carried out in Rosses View Area. 100% Complete.
5. Checklist is in place in relation to the Dryers across Rosses View.
6. New check list is in place re—Daily checks on Fire Escapes.
7. Fire Registers are in place in each area. New fire Register to be issued from estates in January 2017.
8. All PEEP forms to be updated with new Fire Door works completed.
9. Designated centre has 100% fire Training with staff.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

Risks identified relating to healthcare associated infections did not meet the standards for the prevention and control of healthcare associated infections.

**15. Action Required:**

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

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

1. Hand Hygiene training plan of dates is in place for Training for staff, within Rosses View we have 1 Nurse who is a "champion" in infection control. All staff will have Hand Hygiene training by end of January 2017. The hand hygiene training dates were 20th October, 9th November and the next one takes place 13th December 2016.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

The progress made to date on the recommendations contained within the fire safety risk assessment report referred to under Outcome 7 in the main body of the report, indicates that effective fire safety management systems are not in place within the designated centre.

**16. 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:**

1. Fire Works are ongoing at present where Fire Doors are being installed, Emergency

- Lighting is being completed, exit lighting & Fire Repeater panels are completed in the 6 areas. All work commenced in September 2017. On 29th September repeater panels were installed, 3rd November emergency lighting and fire doors commenced.
2. At the present time all compartment door are in position and hung on all units within the main building. The emergency lighting and running man signs are in place and working. The free swing closers and magnetic devices have been installed just waiting connection.
  3. A painter is presently on site painting of New Doors. Painted to be extended across Rosses View following construction works.
  4. Additional Fire Training in the evacuation process will be discussed with external company & Fire Officer HSE in relation to additional training with use of Horizontal evacuation when all Free swing closures & magnetic devices Doors are connected into Fire System.
  5. Monthly Fire Drills are continuing on both Day & Night Duty.
  6. Deep Sleep evacuations have being carried out in Rosses View Area.
  7. Checklist is in place in relation to the Dryers across Rosses View.
  8. New check list is in place re—Daily checks on Fire Escapes, equipment etc.
  9. Fire Registers are in place in each area.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

The fire safety maintenance arrangements in place were not adequate in the following respects:

Fire resistant doors were not maintained in a manner that would ensure they would perform effectively in the event of a fire.

The system of in house fire safety checks required review to ensure they were carried out in adequate frequency and detail.

There were no adequate checks in place to prevent the accumulation of lint in the clothes dryers located within the units.

**17. Action Required:**

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

A robust action plan was initiated immediately in regard to this standard and the following was installed:

1. The Rosses residential centre has been sub-divided into eight (8) No. compartments and six (6) No. sub-compartments ensuring that no more than 3-5 residents are located within each sub-compartment in accordance with the principles indicated within

Technical Guidance Document B and relevant section of Health Technical Memorandum. Four (4) No. refuge areas enclosed in 60 minute fire resting construction including new FD60s doorsets (two (2) in each ward area), have been provided in accordance with best practices.

2. The works carried out constituted new FD30S and FD60S Fire doorset or upgrade of existing fire doorsets.

3. It is confirmed that the mechanisms connected to the doors closers have been connected.

4. All Fire Safety upgrade works on-site are complete and were supervised by this office. The works were carried out in accordance with SI 367 of 2013. ( see report)

5. Monthly Fire Drills are continuing on both Day & Night Duty.

6. Deep Sleep evacuations have being carried out in Rosses View Area. 100% completed.

7. Checklist is in place in relation to the Dryers across Rosses View. 1 lint in St Bernadettes unit Dryer has being replaced.

8. New check list is in place re—Daily checks on Fire Escapes, equipment etc.

9. Fire Registers are in place in each area. 1 person in each area will be responsible for completing the Fire Register in Rosses View centre. Training carried out for staff with the Fire Officer on the 18th October re updating PEEPS and the Fire Register. Format of the fire register will change in January 2017 – same will be updated accordingly.

10. Regular updates have been provided by the PIC to HIQA.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

Adequate means of escape were not provided within the designated centre in the following respects:

The escape routes were not adequately protected with fire resistant construction, for example fire hazard rooms located along escape corridors.

Identified primary means of escape, from a number of units were found to be via the escape corridor and terminating through a day room or dining room.

Ramps provided outside final exits, forming part of the means of escape, were found to be excessively steep and difficult to negotiate. For example, one ramp was found to have a gradient of approximately 1:4, which is far in excess of the maximum recommended gradient of 1:12.

The emergency lighting system was identified as requiring to be checked by a suitably qualified person to ensure it provides the necessary level of coverage throughout the centre and is fit for purpose.

**18. Action Required:**

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape,

including emergency lighting.

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

1. The Rosses residential centre has been sub-divided into eight (8) No. compartments and six (6) No. sub-compartments ensuring that no more than 3-5 residents are located within each sub-compartment in accordance with the principles indicated within Technical Guidance Document B and relevant section of Health Technical Memorandum. Four (4) No. refuge areas enclosed in 60 minute fire resting construction including new FD60s doorsets (two (2) in each ward area), have been provided in accordance with best practices.

2. All Fire Safety upgrade works on-site are complete and were supervised by external company. The works were carried out in accordance with SI 367 of 2013.

3. The works carried out constituted new FD30S and FD60S Fire doorset or upgrade of existing fire doorsets. Hazard rooms have been protected within 60 minute fire resting construction and new FD60S doorsets to separate the laundry area and linen rooms from the main escape routes. It should be noted that the said 'dayroom or dining room' constitute the new refuge areas as noted above. Please note that for the use of premises, it is not recommended to evacuate residents externally into the elements. As part of the overall fire strategy we have provided for two refuge spaces in each ward which can provide secure refuge for residents within a short distance from their sleeping bedroom accommodation. Additionally progressive horizontal evacuation for the residents via sub-compartment lines has been provided. Each refuge area is provided with an external door to the façade of the building with compliant ramp access.

At the present time all compartment door are in position and hung on all units within the main building. The emergency lighting and running man signs are in place and working. The free swing closers and magnetic devices have been installed just waiting connection.

4. Additional Fire Training in the evacuation process will be discussed with external company & Fire Officer HSE in relation to additional training with use of Horizontal evacuation. Training will take place on 13/1/17. Monthly Fire Drills are continuing on both Day & Night Duty.

5. Deep Sleep evacuations have being carried out in Rosses View Area.

6. Checklist is in place in relation to the Dryers across Rosses View.

7. New check list is in place re—Daily checks on Fire Escapes, equipment etc.

8. Fire Registers are in place in each are

9. It is confirmed that the existing escape ramps provided at the end of the Hazelwood and St Raphael's Units do not comply however the fire strategy is now to move residents to the new designated refuge areas where compliant ramps are available, if needs be.

10. External company have assessed the mean of escape from each unit in Rosses view and we are satisfied they comply with SI 367 of 2013. ( see report).

The primary means of escape in the circulating corridors and refuge areas have been provided with new Emergency Lighting by way of new luminaries and exit sign posting in accordance with IS3217:2013. The new Emergency Lighting has been completed and signed off.



**Proposed Timescale:** 31/01/2017

**Theme:** Effective Services

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

There was inadequate provision of fire doors to prevent the movement of fire and smoke throughout the building. The majority of doors provided to fire hazard rooms were identified as having not been provided with intumescent strips, cold smoke seals or self-closing devices.

There was inadequate provision of sub-compartmentation with fire resistant construction to prevent the movement of smoke and fire throughout the building and to provide an area of relative safety for occupants in the event of evacuation of the centre.

The fire rated enclosure to some rooms was not imperforate and contained holes or gaps breaching the line of fire resistance.

**19. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

1. Fire Works are ongoing at present where Fire Doors are being Installed, Emergency Lighting is being completed, exit lighting & Fire Repeater panels are completed in the 6 areas. All work commenced in September 2017.
2. At the present time all compartment door are in position and hung on all units within the main building. The emergency lighting and running man signs are in place and working. The free swing closers and magnetic devices have been installed just waiting connection.
3. A painter is presently on site painting of New Doors. Painted to be extended across Rosses View following construction works.
4. Detectors were installed by external company in a number of rooms that were pointed out on last Inspection that required same to be installed.
5. All Fire Equipment is serviced on an annual basis by external company.
6. Fire Training for staff- Training Plan in place from Estates dept , last training session was 18/11/16. New Fire Training Plan to be forwarded from Estates in January 2017 for next year training times.
7. All new and existing doors as part of the upgrade works have been provided with combined smoke & heat seals and self-closing devices.
8. It is acknowledged that some small gaps may exist to service penetrations, these apertures shall be picked up and fire sealed as part of the snagging works by the Contractor.

**Proposed Timescale:** 28/02/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

Some of the personal emergency evacuation plans (PEEPs) were found to have been not reviewed since January 2015.

The programme of drills in place did not assure the inspector, that drills carried out, were fit for purpose and simulate real life scenarios, for the following reasons:

- The inspector saw the report for one drill, where all residents were in bed. The duration of this drill was excessive at ten minutes.
- There were instances where residents were distressed or were reluctant to leave during the drill and their evacuation was simulated, without identifying alternative methods of reassuring the resident.
- The inspector found that in one of the units in the centre, there was a period during the night shift where the nurse on duty would relocate to another unit to administer medication, leaving one member of staff covering two units.

**20. Action Required:**

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

1. A Fire Procedure is displayed in all areas in Rosses View for Evacuation Purposes.
2. Night Time Evacuation Procedures are in place to ensure during any emergency a staff member will come from other areas to help with Evacuation. The senior person on duty will complete the appropriate medication round where required or in the event the Nurse was absent for any period of time on any particular night , the senior cover manager would replace this absentee , leaving the appropriate staffing in place according to our roster.
3. Simulation Drill - Evacuation Drill has been completed by Fire Company on 27/9/2016
4. A Traffic Light Template is in place to identify who would require more assistance at time of evacuation.
5. All resident are reassured during all evacuations, the prompt for residents is when a Fire Drill is to take place a whistle is blown. A comforting Blanket or item is given to the resident of their choice to reassure them at all times.
6. Night staff use a Pager Alarm system in the event of any staff requiring assistance during Lone Working.
7. Fire Service have been spoken to in relation to Fire Evacuation—They are on site within 7 Minutes to evacuate.
8. Deep Sleep Drills have been completed in Rosses View Service.
9. Day & Night Monthly Drills are completed in each area.
10. Training with HSE Fire Officer in relation to PEEPs & Fire Register has been completed on 8th November 2016.
11. When Fire Works are complete Further training in Evacuation will be sought in relation to New Fire Doors & Procedures required.

**Proposed Timescale:** 28/02/2017**Theme:** Effective Services

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

Some of the drawings displayed throughout the centre portrayed future proposed works, including lines of compartmentation that did not yet exist.

**21. Action Required:**

Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

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

1. Fire Procedures in place across this designated Centre for all staff & residents to follow.
2. Estates Dept will relook at Drawings when all Fire Works are completed across this designated centre to input lines of compartmentation. Follow up with estates to take place in January 2017.
3. On completing of snagging list by contractor, drawings will be completed to have compartmentation lines within

**Proposed Timescale:** 28/02/2017

**Theme:** Effective Services

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

There was a deep fat fryer located in the main kitchen, however an automatic fire suppression system was not provided.

**22. Action Required:**

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

1. Deep Fat fryer only used 2 days a week .
2. External Fire Company has been contacted regarding this issue. Adequate equipment in place re Fire Apparatus Extinguishers & Fire Blanket.
3. Deep Fat Fryer lid in place for same.
4. Automatic Fire Door in place in main kitchen area, which is connected to Main Fire Panel.
5. All staff in Kitchen area aware of this highlighted issue.
6. Fire Exits to the front & back of Kitchen area if evacuation is required.
7. Quote received by external company for automatic suppression system. Same submitted. Approval by Estates & Provider required.

**Proposed Timescale:** 31/01/2017

**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:**

Staff did not have up-to-date training in managing behaviours that challenge.

**23. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

All staff within Rosses View will receive training in Studio 111. Schedule of training will be available to all staff by 31/12/16.

**Proposed Timescale:** 31/03/2017

**Theme:** Safe Services

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

Restrictive practices including, physical, chemical and environmental restraints were used and procedures were not applied in accordance with national policy and evidence based practice.

**24. Action Required:**

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

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

1. All restrictive practices will be used as a last resort and for the shortest possible time
2. All restrictive practices will be approved by the Restrictive Practice Committee
3. Restrictive Practice Log is in place on each unit.
4. The Restrictive Practice policy is in place and is available to all staff.
5. All restrictive Practices are reviewed monthly by the Restrictive Practice Committee which includes the Psychologist and other multidisciplinary team members.
6. The Psychiatrist has completed a workshop in PRN medication (training for staff). The next workshop will be in January 2017, awaiting confirmation of date with Psychiatrist. This training ensures that all staff working with residents in Rosses View will have a clear understanding of the rationale for PRN medication.

**Proposed Timescale:** 31/03/2017

**Theme:** Safe Services

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

1. Nineteen staff did not have Garda Vetting completed prior to commencing employment in the centre.
2. Two of the nineteen staff also did not have up-to-date safeguarding and protection training.

**25. Action Required:**

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

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

1. 2 Staff not trained/updated in safeguarding process will be completed on next training day 15th Dec 2017.
2. National issue remains outstanding regarding safeguarding training- HSE are having communication regarding this issue.
3. As mandated by the legislation we have NO staff who have been employed since the 29/04/2016 without the appropriate Garda Clearance.
4. At the time of the inspection we had one employee employed since 29/04/2016 without appropriate GV, this was rectified immediately and the staff was taken out of this area until this was received. 18 staff are presently going through the process of Garda Vetting in this centre.

**Proposed Timescale:** 31/03/2017

**Outcome 10. General Welfare and Development**

**Theme:** Health and Development

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

1. Residents' daily activities had ceased or were very minimal.
2. Residents were not provided with opportunities to attend regular day activities, training or employment.

**26. Action Required:**

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

1. Dream programme is fully operational with the full complement of staff ( 2 full time staff) where 19 residents receive a service on a sessional basis.
2. Business case has been submitted for replacement of 1 staff in Dream programme

who is going on Maternity leave at the end of December 2016- we are awaiting approval of same.

3. Individual goals have been identified through their individualised living options and their annual review that will support their transition into the community. They are currently undergoing their discovery process with their support person and family.

4. The new Personal plan incorporates an action plan for personal goals under the following headings- social goals, educational goals, communication goals, community involvement goals, skills for independent living, health care skills, recreational skills, maintaining relationships, money management, work-employment.

5. The Dream programme is audited and reviewed monthly to ensure that each person accessing the Dream programme is supported to work towards achieving their personal goals.

6. Nurse Manager carries out an Audit regarding attendance at Dream Programme. Audits are completed on a monthly basis which commenced in October 2016.

7. Community activities are aligned with the personal and social goals as identified in their personal plan i.e. over night stays in hotels, attending concerts & pantomimes, restaurants/cafes, reflexology, beauticians & hairdressers, visiting friends and family in the community. Each person as appropriate visits local churches and ceremonies within their local community.

**Proposed Timescale:** 28/02/2017

## **Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Residents diabetic care was not in line with the residents care plan.

### **27. Action Required:**

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

1. The person's diabetic plan was reviewed and revised by the CNS in Diabetic Care with input from the resident and support person.

2. Next Training for staff on Diabetic Care is 5th Dec 2016 –2 sessions will be held on this day for staff both on Day & Night Duty

**Proposed Timescale:** 31/12/2016

**Theme:** Health and Development

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

The centralised kitchen closed at 3.00pm on a Saturday and Sunday and this limited

meal choices to many residents in the centre.

**28. Action Required:**

Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

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

1. All residents have access to a hot meals of their choice outside of main kitchen closure times.
2. Coney & Benbulbin view have cooking facilities in place.
3. St Bernadettes, Hazelwood & Innisfree use the cooking facilities available in Sunset and Dream area to facilitate the provision of hot meals outside of Kitchen closures in evenings & weekends.
4. All areas have Microvaves in place.
5. 3 Cookers will be installed in areas that require same on completion of Fire Works due to finish Dec 31st 2016.
6. All residents on texture "C" mealtime guidelines use an external provider for their choice of 27 different varieties of suitable meals which are of appropriate nutritional value. A large selection of dinners & savory meals are available.
7. As per personal goals the local community is being accessed at every opportunity by each individual as appropriate to facilitate their future transition.
8. Restuarants and cafes in local communities are accessed by persons for these purposes. Local restuarants and Take Aways will prepare appropriate texture and consistency of meals for individuals as stated in safe meal time guidelines.

**Proposed Timescale:** 28/02/2017

**Outcome 12. Medication Management**

**Theme:** Health and Development

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

1. Night staff were not trained to administer medication to residents, resulting in nursing staff from other units being redeployed to administer medications in up to five units.
2. Residents were not receiving their medication within the timeframe as prescribed.
3. Staff were not trained to administer emergency medication and there were not adequate alternative arrangements in place to ensure the medication would be administered within the recommended time-frame.

**29. Action Required:**

Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of

and not further used as medical products in accordance with any relevant national legislation or guidance.

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

A full review of this finding was completed by the PIC , the following actions have been initiated and completed.

1. Medication Management Protocols are in place across Rosses View in relation to Ordering , Administering, storing, prescribing & disposal of medicines. This is clearly documented in the Medication Management folder in each area.
2. Nurses are rostered to all areas in Rosses View between 8 am and 8.20 pm.  
Anumber of nurses cover Rosses View at night.
3. All medication in Rosses View is administered by a qualified Registered Nurse, which are based on each unit during the Day & a number of Nurses cover each area at Night time.
4. All night time medication administration times at across Rosses View will be reviewed in collaboration with the GP and Psychiatrist in line with the Medication Management Policy
5. Training in Buccal Madazolam (Emergency Medication) is continuing in the service. Staff in Rosses View will be trained in this area .

**Proposed Timescale:** 15/02/2017

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not accurately reflect the service provided in the centre.

**30. Action Required:**

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

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

Statement of Purpose has been updated to reflect the service provided in the centre.

Proposed Timescale: Completed

**Proposed Timescale:** 13/01/2017

**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:**



This management of this service was ineffective. It failed to ensure that residents' needs were being met, that residents were safe or that the care provided was consistent or effectively monitored.

**31. Action Required:**

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

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

1. The management team have reviewed their systems in place to ensure the service is effective

The Rosses residential centre has been sub-divided into eight (8) No. compartments and six (6) No. sub-compartments ensuring that no more than 3-5 residents are located within each sub-compartment in accordance with the principles indicated within Technical Guidance Document B and relevant section of Health Technical Memorandum. Four (4) No. refuge areas enclosed in 60 minute fire resting construction including new FD60s doorsets (two (2) in each ward area), have been provided in accordance with best practices.

2. All Fire Safety upgrade works on-site are complete and were supervised by this office. The works were carried out in accordance with SI 367 of 2013. ( see report)

3. External company has completed a work force review & draft report same has being forward to senior management in HSE.

4. Agency staff used in the centred is being looked at where National recruitment are replacing agency staff.

5. Safeguarding –All staff who has commenced work in this service post 2004 is Garda Vetted. The new regulations has stated that all staff under these guidelines have to be Garda Vetted by end of Dec 2017.

6. Detectors were installed by reputable external Company in a number of rooms that were identified on last Inspection. Audit carried out by professional competent external contractor to complete this process.

7. All Fire Equipment is serviced on an annual basis by external company.

8. Fire Training for staff- Training Plan in place from Estates dept Letterkenny, last training session was 18/11/16. New Fire Training Plan to be forwarded from Estates in January 2017 for next year training dates, this will include compartmentation training also. 110% Fire Training across this designated centre.

9. Hand Hygiene training schedule is in place, within Rosses View we have 1 Nurse who is a " champion " in infection control. All staff will have Hand Hygiene training by end of January 2016. Cleaning schedules in Place across this designated centre for Infection Control.

10. Medicals for residents are ongoing across this designated centre.

11. All Risk Registers are reviewed on a monthly basis. September October & November Risk Register reviews have been undertaken and risk ratings have been reduced as appropriate.

12. The new Personal plan incorporates an action plan for each personal goals under the following headings- social goals, educational goals, communication goals, community involvement goals, skills for independent living, health care skills, recreational skills, maintaining relationships, money management, work-employment.

13. A template in the action plan incorporates the following- Date goal was agreed,

action required to achieve the goal, who will support me, the date the goal was actual achieved & if not, why not. Under the outcome for me –was it enjoyable, did I learn anything & will it improve my life. This is the process for personal goals going forward.

14. All new documentation is on the Shared Drive for staff to access.

15. 2 training workshops have being completed on the 7th & 14th Nov in relation to the new documentation. Additional training workshops to be completed in January 2017.

16. As of 21 Nov 2016 Dream programme became operational with the full compliment of staff (2 full time staff) where 19 residents receive a service on a sessional basis. This programme delivers a person centred approach from information gathered in the "listen to me documentation" . This programme is led by the residents.

17. Annual Review on New Template has being completed across Rosses View. This is made available to all staff & representatives. Quality Improvement Plan is developed from this annual review.

18. 6 Monthly unannounced visit will be completed by 28/ February/2017 by the PIC.

19. Performance Management Governance meetings have taken place with Managers & staff across this designated centre. A Management Structure is in place across this designated centre where staff Nurses report to the 2 CNM2s who in turn report to the PIC who is the service area manager in the area and the leader of the team. The PIC & CNM2s have appropriate skills, qualifications & experience to lead in this designated centre. Walkarounds are completed by the CNM2s each day in their respective units.

20. Garda Vetting is being completed on remaining outstanding staff. According to the legislation as of the 29th April 2016 all staff must be Garda Vetted by the 31st December 2017. A staff has been assigned to process the forms for Cregg Services staff from January 2017 in order to comply with the legislation.

21. PIC Workshop x 2 days has been completed by all PICs within the Service, Oct 26th & 27th 2016

22. Decongregation plan has been submitted to HIQA by the Provider. Compatibility templates are being completed by same with residents & families.

**Proposed Timescale:** 28/02/2017

**Theme:** Leadership, Governance and Management

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

The six monthly unannounced visit by the provider or nominated person did not identify areas of concern and put a plan in place to address previous actions and further non compliances with the regulations.

**32. 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:**

1. The nominee provider has completed an unannounced inspection within this centre

this has contributed to the Annual Report which has been completed on this designated Centre in November 2016.

2. A 6 Monthly Inspection report will be updated across this designated centre by 28/2/2017 to show the quality & safety of care & an action plan devised to address any concerns.

**Proposed Timescale:** 28/02/2017

**Theme:** Leadership, Governance and Management

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

Staff were not supported to develop their skills, or to exercise their personal or professional responsibilities to improve the quality and safety of the services. For example, staff were not up-skilled in risk management.

**33. Action Required:**

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

1. Risk Workshop was completed by External person from HSE in service in Sept 2016.
2. Training sessions were completed by the Risk Management team in Cregg Services June 2016
3. Further Risk workshops will be completed by the end of February 2017 for staff across Rosses View service.
4. Individual risk assessments are completed for each individual and reviewed as appropriate
5. A safety statement is available for this centre, operational and environmental risks are managed in this as appropriate.
6. Risk Registers are in operation for each area in this centre. A risk register for Rosses View is reviewed monthly, all risks are updated monthly.
7. A daily walkaround is completed by local managers
8. All staff are made aware through regular meetings of the importance of safety at all times.
9. Induction and Orientation is undertaken with all staff
10. Quality and Safety Governance meetings are conducted weekly on a regular basis
11. Daily handover communication tool is implemented twice over a 24 hour period
12. Schedule of Staff Performance Management Agreement is currently underway within the centre.
13. Health and Safety meetings are conducted 2 monthly.
14. Safety reps are available in this centre.
15. NIMS reporting is standard within the service, all incidents are reviewed on a monthly basis at local level and following this the Incident Review Group review all incidents and learning is shared across the service.
16. Personal Plans are available for all persons in this centre.

- 17. Safeguarding concerns are screened as per the National Safeguarding Policy and submitted to the Safeguard and Protection Team
- 18. Designated Officers are available within this centre
- 19. This centre is supported by the wider MDT team which a Social Worker has joined since end of September 2016
- 20. Complaints are responded to as per Your Service Your Say Policy
- 21. Restrictive Practice Committee is in operation chaired by Psychology

**Proposed Timescale:** 28/02/2017

### **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 inadequate transport available to residents.

#### **34. 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:**

1. Presently we have had a number of contacts from external agencies regarding Transport Vehicles. They have come to the service with vehicles to be viewed. Suitability is an issue.
2. External Agencies to come back with Quotes regarding same, possibility of leasing transport is also an option.
3. Rosses View has 1 wheelchair accessible Bus for use, this is to be shared out with each unit.
4. Evening & weekends other Buses across service are available to Rosses View.
5. Taxis Buses are used if/when required for residents to meet their social needs, will & preferences.

**Proposed Timescale:** 28/02/2017

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

There was a high reliance on agency or relief staffing to support residents daily. However, the hours that agency staff work are inconsistent and often agency staff are unfamiliar to residents which resulted in negative outcomes for residents.

**35. Action Required:**

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

1. Presently the National Recruitment Service are recruiting staff to replace agency, as staff come through the system they are replacing the agency within the service.
2. We have presently only 3 staff members on Agency Hours within this designated centre. These are familiar staff, 1 staff is working on a full 39 hr line & other staff is supporting weekend Hours.
3. Agency staff have upto date training.
4. Emergencies & covering of sick leave would be a time we may get unfamiliar staff from Agencies.
5. 2 Managers in the service are continuing their training with GENIO in relation to being Transition officers within the service. Next training dates are 5th, 6th & 7th Dec 2016.

**Proposed Timescale:** 28/02/2017**Theme:** Responsive Workforce**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

An inadequate number of staff were working in the centre to support residents with all aspects of their needs.

**36. Action Required:**

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

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

1. Training completed with all managers and staff in the service in July 2016 by external company in relation to assessing the needs of each person, the appropriate skill mix of staff, the statement of purpose and the size and layout of the designated centre.
2. We are presently completing a detailed Work Force Review that is being overseen by an external company. Recordings of Daily Caseloads have been completed for 5 set days & Nights & activity summary sheets completed.
3. All paperwork and rosters have been sent to external company ( England) in November 2016. Feedback is awaited by External Company who will indicate through feedback the commencement and completion of a quality audit which is the final stage of the staffing review process. A final report will be issued following the completion and submission of the quality audit to the External Company.

**Proposed Timescale:** 28/02/2017

**Theme:** Responsive Workforce

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

A significant number of staff did not have the required mandatory up-to-date training.

**37. Action Required:**

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

1. Training Needs Analysis was completed & forwarded to Centre of Nurse & Midwifery of Education in 1st Quarter 2016.
2. All staff have a 100% Fire Training in Rosses View Service.
3. Safeguarding Training is ongoing in the service—next Training day is 15th December—8 staff as mentioned in report will be completed on this day. Safeguarding survey completed across Rosses View in November 2016.
4. Moving & Handling Dates are in place from Occupational Health Department – these dates are in place up until Dec 15th 2016. Other dates to be forwarded for 1st Quarter of 2017 by Occupational health Department . We are allocated 1-2 places on each weeks training for the service.
5. Hand Hygiene training will be completed for staff in Rosses View by end of January 2017. Next training sessions is December 13th 2016.
6. Diabetes Training—
7. Epilepsy management training/ Buccal Madazolam , last training session was 10th Nov, other dates to be set by Epilepsy Ireland for Rosses View for 1st Quarter 2017.
8. There is 100% compliance in staff training for safeguarding and protection and fire safety and evacuation. There is 80% compliance in staff manual handling; a schedule is in place to ensure compliance in this training. There is 48 % compliance in Studio 3 training a schedule is in place to ensure compliance here also.
9. All positive behavioural support plans are in place as required, CNS in behaviours reviews as needed.
10. Mental Health ID team are available as part of the wider support team.
11. Psychologist has increase hours within the service to 32 hours per week and is available as part of support for individuals.
12. Support from Autism Services on a regular and ongoing basis

**Proposed Timescale:** 31/03/2017

**Theme:** Responsive Workforce

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

Staff had not received formal support and supervision from their managers.

**38. Action Required:**

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately

supervised.

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

1. Managers in a supernumery capacity are available to all staff within this centre over a 24 hour period
2. Staff are supervised by managers on a daily basis
3. Performance Management Governance meetings have taken place with all Managers across this designated centre.
4. Performance Management Governance meetings have commenced with all Staff Nurses across this designated centre. This to be completed by 28 th February 2017.
5. Staff Meetings take place with Managers on a weekly basis for discussions & communications from Quality & Governance meetings.
6. Daily Walkaround by the Managers are completed, all actions identified on walkabout are followed up and addressed locally.
7. Unannounced walkaround by PIC are ongoing on a continual basis, action plan is developed to address all concerns identified.
8. Learning from all walkabouts are discussed at regular team meetings, action plans are updated at these meetings time frames and responsible persons are identified for all actions. All meetings are documented and stored locally in hard copy in each area.

**Proposed Timescale:** 28/02/2017