

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Centre 3 - Aras Attracta
<b>Centre ID:</b>	OSV-0004911
<b>Centre county:</b>	Mayo
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Suzanne Keenan
<b>Lead inspector:</b>	Catherine Glynn
<b>Support inspector(s):</b>	Jackie Warren
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	28
<b>Number of vacancies on the date of inspection:</b>	0

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

From:	To:
18 October 2016 11:00	18 October 2016 20:30
19 October 2016 09:30	19 October 2016 17:30

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

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

**Summary of findings from this inspection**

There are three centres on the Aras Attracta campus, Centre 1, Centre 2 and Centre 3. Following inspections in 2014 and 2015, inspectors found that the provider was failing to ensure that residents had a safe and good quality services. The provider submitted a plan to the Health Information and Quality Authority (HIQA) about how it proposed to improve the services and HIQA undertook a programme of inspection days to verify whether the actions were resulting in a positive impact in the safety and quality of service for residents. The inspection days for Centre 3 were

11 January 2015

12 July 2015  
30 March 2016  
18 October 2016

Following the initial inspection days, inspectors found that the provider was implementing their action plan but that the actions were not resulting in sufficient improvements in the quality of life for residents. Subsequently, in October 2015 HIQA required the provider to undertake an audit of their services under regulation 23 using a template provided by HIQA, and to submit an action plan to HIQA based on that audit. The provider was then required to repeat that audit three months later and to assess themselves on the impact of their action plan from the initial audit.

Inspectors then continued with their programme of inspection days and found that while there were still significant non-compliances, the provider was making progress in relation to improving safety and quality of life of residents.

This report records the progress of the provider as found on the most recent of those inspection days in October 2016.

In general, while there continues to be areas where the provider is not yet meeting the requirements of the regulations, inspectors found that the safety and quality of life for residents had improved over the course of the inspection programme. Inspectors found that there had been improvements in the following areas:

- Residents had increased access to the community and were participating in more activities of their choice.
- All the residents had individual bedrooms which were decorated to their choice.
- Residents' healthcare needs were being met and there was timely access to medical care and allied health services.
- Staff were knowledgeable and trained regarding safeguarding residents.
- Auditing and monitoring of the quality of the service had improved.
- Residents were accessing activities and achieving goals as part of their goal planning process.
- Individualised assessments had not been completed for all residents.

However, the provider continues to have non-compliances in the following areas:

- Risk management, fire management and medication management required improvement.
- The use of centralised practices continued to limit choice for some residents, in particular relating to mealtimes.
- A review of the staffing skill-mix and levels remained outstanding.
- There were deficits regarding aspects of staff training.

The current findings are set out in this report and the areas of non-compliance are included 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:**

The inspectors found that overall there was evidence of good practice with regard to residents' rights and dignity, however further improvement was required with regard to some practices. The inspectors found that while some residents were facilitated to exercise choice in services, other residents were not supported; for example, choosing meal time routines.

The inspectors found that arrangements were in place to ensure residents' privacy and dignity was promoted. For example, all residents had a private bedroom in the designated centre. Residents were pleased to show inspectors their rooms and discussed their chosen décor and furniture. Residents had keys to their rooms which ensured they had privacy and allowed to safely store personal belongings. Inspectors noted that staff knocked on entering residents' bedrooms and consulted with residents with regard to accessing or entering their rooms.

Advocacy was available in the designated centre and information was readily displayed throughout. An easy-to-read format was available for residents where required. Residents were actively engaging with advocacy through their day services and in the local community. Residents spoken with were informed and aware of their rights. This was discussed at house meetings, as evident on review of minutes. Residents' rights were prominently displayed throughout the designated centre.

The inspectors found that some residents had access to a general practitioner (GP) and pharmacy of their choice, but other residents were reliant on a campus-based service.

Some residents continued to attend a day service based on the larger campus setting. The choice in activities was limited at this day service and on occasion effected by staffing levels.

The inspectors found there were arrangements in place for visitors to attend the centre. Since the last inspections visitor rooms were now available.

There was a complaints process in place and the nominated complaints person was readily identified by staff and residents. The identity of the nominated complaints person was displayed throughout the designated centre. Residents were informed and aware of who to consult with if they had a complaint or annoyance. The complaints log was reviewed and inspectors found that the recording system was poor. The template did not identify whether actions were addressed for active complaints and there was no record of whether the complainant was satisfied or not.

Inspectors found that residents were consulted with through house meetings and service planning, especially with regard to the de-congregation plan and transitional planning. Residents spoke about their engagement in planning, decorating and facilities in their new accommodation in the community.

The inspectors found that residents' finances were managed in a clear and transparent manner. All money was securely stored and was accessible to residents whenever they needed it. Individual balance sheets were maintained for each resident, all transactions were clearly recorded and signed, and receipts were maintained for all purchases.

**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:**

Overall, the inspectors found that communication systems had improved in the designated centre, however further improvement was required to ensure the communication needs of all residents were clearly identified.

Supports and aids were in place to assist residents with aspects of their communication needs. For example, picture boards were evident throughout the designated centre. The

inspectors were informed that a speech and language therapist (SALT) was available to the campus and staff confirmed their input in the implementation and development of the picture boards. The inspector also observed the use of sign language systems suitable for the residents.

While inspectors found a number of communication plans in place, the quality varied among them and some lacked appropriate detail.

Residents had access to televisions, radios, computerised devices and mobile phones. Inspectors found that residents also had access to the internet. Residents had also accessed external agencies to gain support regarding sensory deficits and to access suitable technology to enhance their communication skills.

**Judgment:**

Substantially Compliant

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

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

The inspectors found that residents were supported to develop and maintain links with family, friends and the wider community.

It was evident that residents were supported to maintain links with family from a review of daily logs and personal goals. Family contact sheets were maintained to reflect residents' contact with families. Families were actively involved in aspects of residents' care and support needs, where required. Families were consulted with regards to transitional plans for residents and met on a frequent basis with the management team in the designated centre.

Inspectors observed that residents had pictures of attending family events in their individual bedrooms. Residents spoke openly in regard to being supported to attend family events such as birthday parties and also being able to speak to family members on the telephone. Residents also stated that family members could visit the centre if they wanted.

The inspector reviewed activity records within the centre which detailed that residents were actively involved in their local community and were regularly visiting local shops, hotels, restaurants, barbers and hairdressers.



**Judgment:**

Compliant

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

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The inspectors found that while there were policies and procedures in place to facilitate the transfer, admission and discharge of residents, some improvement was required regarding the contracts of care.

There were policies and procedures in place to support the transfer, admission and discharge of residents in the designated centre. Transition plans were in place for a number of identified residents in the designated centre. Inspectors were informed that 15 residents would move as part of a restructuring de-congregational plan from the centre. Transition plans were in place for these residents. One resident had successfully transitioned to the community and alternative services since the last inspection.

Inspectors found that consultation had been sourced with external agencies for staff to receive training and support to facilitate residents during the transitions. Training was provided to staff by the external agencies in, for example, strategies to manage behaviours that challenge, social engagement and integration with the community. This was part of an overall review of individual assessments with regard to compatibility and living arrangements for all residents in the centre. This was an on-going process at the time of inspection, and further training was underway.

The inspectors found that improvements were required to the contracts of care. While each resident had a contract of care, full information regarding the fees to be charged was not provided. Inspectors also found that the models of care provided differed in each house, but this was not reflected in the charges incurred by the residents. For example, the charges for waking staff to provide care at night was in place regardless of whether waking staff were allocated in that house.

**Judgment:**

Substantially Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

The inspectors found that there was improvement in the assessment of needs for residents within the centre at the time of inspection. However, this process was ongoing and additional training and support for all staff was required to complete the assessment process.

Personal plans were in place for all residents in the centre at the time of inspection. The inspectors found that additional plans had been completed, such as transitional plans and compatibility assessments. These reflected a new holistic model of care from the previous medical-based model. This new assessment tool was not in place for all residents throughout the six houses.

Inspectors found that residents' personal plans were at differing stages of development throughout the centre. The inspectors found that personal plans for residents transitioning out of the centre had been prioritised to support the quality of care and supports residents' required to successfully transition. The inspectors also found that different models of care were in place throughout the six houses in the designated centre. Where the older model of care planning remained, inspectors found that the activities for residents were not holistic and instead focused on a task-orientated approach. For example, medical needs and routine of the service. The inspectors also found that where the task-orientated approach remained, social activities were limited and relied on the centralised practices such as day services and facilities on the larger campus setting.

The inspectors found that residents had been supported to achieve their goals, for example, having a pet, attending bereavement support, visiting relatives, accessing the community, cookery courses, life skills, employment and driving classes. Inspectors also found that there were active ageing plans in place where required. These outlined the choice for residents to retire from campus-led activities and be supported to remain at home if that was their wish.

**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:**

Inspectors found that improvements had been made to refurbish and renovate three houses in the designated centre. The other three houses had also undergone aspects of painting and decorating, but further work was required.

The inspectors found that there were adequate bathroom, shower and toilet facilities in the designated centre. However, in one bungalow there was a noticeable deterioration of the fabric and fittings of the bathroom. This was also identified in an internal hygiene audit; however, no action was identified to complete it.

Inspectors found that there was adequate communal space for residents to engage in activities or facilitate visitors in private. With the reduction in the numbers of residents in all houses, the management team had ensured a room was allocated as an additional sitting room or visitors' facility in each house. Work was on-going to complete the decorating and furnishing of these rooms at the time of inspection.

**Judgment:**

Substantially Compliant

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

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

**Theme:**

Effective Services

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

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

implemented.

**Findings:**

Inspectors found that improvements had continued since the previous inspection days in risk management and health and safety within the centre. However, further improvements were required regarding fire management systems.

Risk management procedures were evident in the centre from a review of the residents' files. The inspectors found risk assessments were completed and the control measures were proportionate to the identified risk. Incidents were recorded and reported in line with the organisation's policies and procedures. A health and safety management committee was in place. The inspectors noted that improvements to fire precautions in the designated centre had not been completed. A fire risk report had been completed in all houses in the designated centre; however, the provider had failed to respond to the actions outlined within the recommended timeframes. For example, the requirement to upgrade the existing emergency lighting throughout the centre.

Inspectors discussed fire safety with staff on duty during the course of the inspection. Staff outlined that a pager system was in place in the centre. Once activated it alerted staff working in other areas to respond and support as required. This system was tested on a weekly basis. However, this system was reliant on the number and availability of staff to attend which fluctuated during day and night-time working hours. The inspectors reviewed a fire risk report completed by an external consultant which identified deficits in the emergency lighting. At the time of inspection this had not been addressed.

Improvements were required from the last inspection included training for staff in fire safety and maintenance of fire safety records for the centre. The inspector reviewed training records and found that all staff had received training in fire safety. The inspectors found from a review of the fire safety folder that checks were in place for emergency lighting, fire exits and equipment provided in the centre. Inspectors found that there were no fire doors in place in the designated centre at the time of inspection.

Inspectors found that personal emergency plans were in place for each resident, which identified the required staffing level to support them in an evacuation. However, this was not reflective of staff numbers on duty at the time of inspection. Further information was also required to ensure they were reflective of residents' assessed needs.

**Judgment:**

Non Compliant - Major

**Outcome 08: Safeguarding and Safety**

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

*to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**

Safe Services

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

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

**Findings:**

During the inspection, inspectors found that safeguarding residents from the risk of abuse was promoted within the designated centre.

The inspectors spoke with residents who reported that they felt safe and supported in their home. Inspectors found that all incidents, allegations or suspicions of abuse were recorded and reported in the centre, and were appropriately investigated in line with national policy. There were no restrictive practices in place in the centre at the time of inspection that impacted on residents.

All incidents, allegations or suspicions of abuse were recorded within the designated centre and were appropriately investigated and responded to, in line with the centre's policy, national guidance and legislation. All incidents reported were reviewed within 24 hours by the management team. Weekly safeguarding meetings were in place with a triage system to review all incidents. Referral to external agencies was also outlined, for example, notifications to HIQA and Gardai. Staff spoken with stated the designated officer was diligent with the review of all safeguarding concerns and ensured all residents were kept informed of any actions regarding reported concerns.

Safeguarding plans were in place where required and were reviewed in accordance with procedures. The plans were updated to reflect any changes of supports required.

The inspector found that behaviour support plans were in place for residents where required. The organisation had recently commenced a new approach in the management of behaviours that challenge. Training had commenced and was still ongoing at the time of inspection. Fourteen staff out of 38 had completed this training. In addition, the trainer was also engaging with the organisation to provide specialist support. The inspector observed that staff acted in accordance with a behaviour support guidelines with a resident when they showed signs of escalation in behaviour. Staff acted respectfully and implemented the guidelines successfully without upset or distress to the resident.

The provider had taken action in houses where there had been peer-to-peer altercations to review compatibility of residents and respite arrangements. This had resulted in a reduction in incidents.

The inspector found that behaviour support plans were in place for residents where required. The organisation had recently commenced a new approach in the management of behaviours that challenge. Training had commenced and was still

ongoing at the time of inspection. Fourteen staff out of 38 had completed this training. In addition, the trainer was also engaging with the organisation to provide specialist support. The inspector observed that staff acted in accordance with a behaviour support guideline appropriately with a resident when they showed signs of escalation in behaviours. Staff acted respectfully and implemented the guidelines successfully without upset or distress to the resident.

In houses where there had been peer to peer altercations the provider had taken action which looked at compatibility of residents and the respite arrangements. This resulted in a reduction in incidents.

**Judgment:**

Compliant

**Outcome 09: Notification of Incidents**

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

**Theme:**

Safe Services

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

No actions were required from the previous inspection.

**Findings:**

On the day of inspection, the inspector found that the person in charge maintained a record of all notifications which had been submitted to HIQA.

The person in charge was also knowledgeable in relation to events which should be notified to HIQA. The inspectors found that a record of submitted notifications were maintained in the designated centre and were accessible when required.

**Judgment:**

Compliant

**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:**

Residents were supported to participate in education and training to assist them to achieve their potential. The inspector found that residents had opportunities for new experiences and to develop further skills.

Residents were involved in basic household chores, such as baking and laundry, as a form of skill building. During the inspection, inspectors observed residents making meals. Some residents stated that they were involved in doing their own laundry and some housekeeping in certain areas of the centre.

There were a range of developmental and social opportunities available to residents in both the day service and the local area. For example, one resident was very involved in handmade craft classes and also in a local community art class which had a public exhibition scheduled. Other activities which residents were involved in included drama, computer classes, life skills and money management. Another resident spoke with the inspectors about their driving lessons and looked forward to completing this process.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

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

**Findings:**

Inspectors found that residents' healthcare needs were well met and they had access to a general practitioner (GP) and other healthcare services as required. However, further improvement was required to support residents with their healthcare needs.

Residents had access to a range of health services including physiotherapy, speech and language therapy and occupational therapy, and referrals were made as necessary. Reports from these reviews were recorded in residents' personal files and recommendations were used to guide practice. In addition, other external healthcare services were arranged, such as visits with the optician, chiropodist, dentist and dental hygienist.

Individualised support plans were in place for all residents' assessed healthcare needs. These plans were clear and provided detailed guidance to direct staff.

Residents' nutritional needs and weights were kept under review and any identified issues were addressed. For example, referral to the dietitian for weight management guidance was available where required. On the evening of the first day of inspection, inspectors observed a home cooked meal being prepared which appeared wholesome and nutritious. Inspector noted that the mealtime was a communal event in which residents and staff ate together. However, inspectors found that there remained a reliance on centralised practices with regard to meal preparation in parts of the centre. Meals were delivered from a campus canteen for the residents or the residents attended this canteen as part of their day service programme on campus.

**Judgment:**

Substantially Compliant

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

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

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

**Findings:**

Inspectors found that residents were protected by safe medication management policies and practices. However, improvement to the storage of unused or out-of-date medication was required.

On review of the medication storage facilities, the inspectors found that medication for return or which had been discontinued were stored separately from the current medications, but were not recorded as required by local policy. The inspector found no recording sheet of medication returns in one medication trolley. This medication remained in the trolley until removed by the pharmacist at the end of the medication cycle. There were no measures in place to prevent misappropriation of unused medication occurring as a result of not logging all unused or discontinued medication as required. The inspector found that this was not the practice in all areas of the centre. A log of medication returns was kept in another trolley and reflected all products held in the storage facility.

In some houses staff supported residents to order, collect and self-administer medications as prescribed. These residents had self assessments completed; however,



not all residents were afforded the same opportunity. The inspectors found that not all residents had a self-assessment for the administration of medication completed.

Inspectors found that written guidelines for the administration of as required (p.r.n) medication were in place but had not been signed by the prescribing practitioner. The person in charge was aware this was outstanding at the time of inspection.

In some houses staff supported residents to order, collect and self administer medications as prescribed. These residents' had self assessments completed however not all residents were afforded the same opportunity; the inspectors found that not all residents had a self assessment for the administration of medication completed in the designated centre.

Inspectors found that written guidelines for the administration of as required (p.r.n) medication were in place but had not been signed by the prescribing practitioner. The person in charge was aware this was outstanding at the time of inspection.

**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):**

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

**Findings:**

The inspector found that the statement of purpose described the services provided in the designated centre and met the majority of the requirements of the regulations, however it required further improvement to reflect the service provided in the designated centre.

The centre had recently reconfigured which resulted in an increase in the number of houses and services provided. The capacity of the centre was not clearly outlined in the statement of purpose and did not reflect the maximum number of residents that could be accommodated at any time in the designated centre, inclusive of full-time residential and respite persons. The centre facilitated respite services for a number of service users, which was outlined in the statement of purpose.

**Judgment:**

Substantially Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Inspectors found that management systems were in place to ensure that the service provided was safe and appropriate to residents' needs. The inspectors found that improvement was required with regard to staff support.

On the day of inspection the person in charge had been in the role for two days. This was part of a recent reconfiguration process due to management restructuring in conjunction with the re-distribution of houses within the centre. The inspectors found that the person in charge was working full-time in the centre and suitably qualified for the position they held in line with the requirements of the regulations. During the course of the inspection, the person in charge was present and available to inspectors when required. He provided a walk-around of all houses and facilities within the designated centre. As part of this process, he presented thorough and comprehensive knowledge of residents' needs and the plans in place regarding the service.

There was an on-call system in place for the designated centre and staff were informed and aware of the procedures regarding the on-call system. All staff and residents were familiar with the person in charge. He was observed to be respectful and engaging with the residents when interacting with them.

Three-monthly reviews of the quality of care and supports were completed in the designated centre at the time of inspection. However, no annual review was completed at the time of inspection.

Staff meetings took place on a monthly basis. The management team had support systems in place, however there were no formal support systems in place for staff working in the centre. Staff spoken with stated that the person in charge was accessible and offered regular informal support and guidance when required.

**Judgment:**

Substantially Compliant

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**Outcome 15: Absence of the person in charge**  
*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**  
 Leadership, Governance and Management

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

**Findings:**  
 The person in charge and his line manager were aware of the requirement to notify HIQA of the absence of the person in charge.

There were arrangements in place to cover the absence of the person in charge both during planned absence and out-of-hours. This process was reflected in the statement of purpose. The designated centre had two registered people participating in management at the time of inspection. These managers were supernumerary and held responsibility for the day-to-day running of the designated centre.

In addition, there were two clinical nurse managers in place who also provided additional clinical support within the centre. They also provided cover for absence of the person in charge where required. The arrangements in place also outlined that in a longer absence exceeding 28 days, the provided would appoint a suitable person to fill the role.

**Judgment:**  
 Compliant

**Outcome 16: Use of Resources**  
*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**  
 Use of Resources

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

**Findings:**  
 During the inspection, the inspectors found that the centre did not have adequate

resources to meet the assessed needs of residents at all times.

The inspectors found that there was adequate transport available and additional vehicles had been sourced throughout the centre. Three staff spoken with reported there had been improvements since the last inspection with regard to access to the community as a result of increased access to transport.

Inspectors observed that staff attended training during working hours which had a direct impact on the service provision to residents and their daily programmes. For example, the inspectors observed two staff attending alternate training sessions as part of their frontline working hours. The inspectors found that no additional staffing was provided to ensure the needs of residents were met while staff attended training.

Following the previous inspection, the provider stated they would undertake a staffing review. This had not been completed at the time of inspection.

**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:**

Actual and planned staff duty rosters were available in all houses in the centre. These outlined the start and finish times of staff working as required from the last inspection.

There was no formal supervision in place for staff at the time of inspection. Staff had informed inspectors that they had received informal supervision, but this was not consistent throughout the centre and a schedule had not been established due to the outstanding training requirement for persons in charge and team leaders.

From a review of training records, staff had received mandatory training in the designated centre, such as fire safety, safeguarding and manual handling. Further training remained incomplete in areas such as management of behaviours that challenge and person-centred goal planning. Inspectors were informed that the training

programme had been delayed due to staffing and funding priorities.

Inspectors found that the provider had a system in place with regard to Garda vetting procedures which was led by the organisation's policy and procedures with regard to recruitment and screening of staff. The inspector reviewed a sample of staff files and found that a copy of staff vetting disclosures were maintained on the personnel file with a letter attached from a Garda vetting liaison officer confirming that this process was completed and that the original document is held in a central file away from the designated centre.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

No actions were required from the previous inspection.

**Findings:**

During the inspection, the inspector found that records were maintained to a good standard in the designated centre.

The inspectors found that all records described in Schedule 5 of the regulations were available and were recently reviewed.

The inspectors also found that all records as stated in Schedule 3 of the regulations were also in place. Overall, the inspector found that records were well maintained, readily available and were reviewed on a regular basis.

**Judgment:**

Compliant

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Catherine Glynn  
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-0004911
<b>Date of Inspection:</b>	18 & 19 October 2016
<b>Date of response:</b>	18 December 2016

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

Some residents in the centre were still reliant on centralised practices which impacted their ability to be involved in the day-to-day activities of living and to make informed choice regarding the running of their home.

**1. Action Required:**

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

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

The remaining units in Centre Three are moving towards this model. Currently two of the 6 homes in this centre are effectively working with this model. A third home is planned to open with this model from 9th of January. A 4th house operates partially as a social care model and its full transition should be completed at the end of February 2017. The remaining two houses will have completed their transition by April 2017. The recruitment of new care assistants who are currently going through the recruitment process will assist with this process. The presence in the service of Social Care staff is assisting with this roll out. Catering, cleaning and laundry services are reducing in line with this process.

**Proposed Timescale:** 30/04/2017

**Theme:** Individualised Supports and Care

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

A comprehensive record of all complaints that was clear and transparent and reflected the requirements of the regulation was not maintained.

**2. Action Required:**

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

There is now a clear comprehensive transparent record maintained of all complaints which fully reflects the requirements of the regulations.

**Proposed Timescale:** 19/12/2016

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

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

Communication plans completed did not clearly outline residents' communication needs.

**3. Action Required:**

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.



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

A full internal audit of all communication plans is currently under way and will consider the individual needs of the residents. A full comprehensive communication action plan will emanate from this to ensure that all residents have a communication plan in place by the end of January 2017. A pictorial choice board has been developed whereby individual residents social choice is being displayed on a daily basis. Also the centre is developing, LAMH initiatives for example "Sign of the Week", communication passports, talking mats, pictorial choices in areas like the restaurant with input from the Speech and Language Therapist. This is being included in the unit induction process for all staff.

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

**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:**

The schedule of fees was not clear and transparent for the residents and also did not reflect a change in need or model of care provided.

**4. 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:**

Currently the contract for the provision of services is under review. The fees charged to the residents will be clearly identified and added to their contract. The new contracts will be available and issued to all individuals.

**Proposed Timescale:** 23/01/2017

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

While the person in charge had implemented comprehensive reviews of individualised assessments this remained on-going at the time of the inspection for all residents in the centre.

**5. 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:**

A complete audit of all of the assessments that have been completed was carried out. Any outstanding assessments have been completed. In addition an SIS A was completed in 2015 and additional profiling support work has been completed in preparation for the move from the campus.

**Proposed Timescale:** 19/12/2016

**Theme:** Effective Services

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

While assessment of needs had been carried out and reviewed for some residents living in the centre, there remained evidence of inadequate social care and supports provided to residents in the designated centre awaiting the implementation of the social care model.

**6. 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:**

The remaining units in Centre Three are moving towards this model. Currently two of the 6 homes in this centre are effectively working with this model. A third home is planned to open with this model from 9th of January. A 4th house operates partially as a social care model and its full transition should be completed at the end of February 2017. The remaining two houses will have completed their transition by April 2017. The recruitment of new care assistants who are currently going through the recruitment process will assist with this process. The presence in the service of Social Care staff is assisting with this roll out. Catering, cleaning and laundry services are reducing in line with this process.

**Proposed Timescale:** 30/04/2017

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

Not all of the houses in the centre were adequately maintained internally and externally.

**7. Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

Since inspection a significant program of painting, decorating and grounds work has been completed. Further work will commence with a bathroom area and will be completed by the time frame.

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

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

**Theme:** Effective Services

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

The provider had failed to address the fire systems identified as requiring review as part of a fire risk report.

**8. 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:**

A further risk assessment of the service has been completed by a competent person. Estimates have been submitted and are awaiting approval at a national level. However it is envisioned that some of the individuals currently residing in this Centre will transition off the campus. The service has upgraded the fire alarm system to enhance the detection of fire, all staff have a panic alert and pager system which is checked regularly and will alert staff in the event of a fire. There are adequate numbers of staff available to evacuate residents in the event of fire. Deep sleep fire evacuations have been completed and the fire policy has been updated.

**Proposed Timescale:** 09/05/2017

**Theme:** Effective Services

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

The provider had failed to ensure adequate emergency lighting was available in the designated centre at external routes.

**9. 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:**

A further risk assessment of the service has been completed by a competent person. There is some emergency lighting in place but it does not meet with current regulations. Estimates have been submitted and are awaiting approval at a national level. However it is envisioned that some of the individuals currently residing in this Centre will transition off the campus. The service has upgraded the fire alarm system to enhance the detection of fire, all staff have now have torches, a panic alert and pager system which is checked regularly and will alert staff in the event of a fire. There are adequate numbers of staff available to evacuate residents in the event of fire by day and by night. Deep sleep fire evacuations have been completed, PEEPs have been updated for all individuals to reflect this and the fire policy has been updated.

**Proposed Timescale:** 09/05/2017

**Theme:** Effective Services

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

Adequate means of containing fire was not evident in the centre.

**10. 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:**

A further risk assessment of the service has been completed by a competent person. Estimates have been submitted and are awaiting approval at a national level. However it is envisioned that some of the individuals currently residing in this Centre will transition off the campus. The service has upgraded the fire alarm system to enhance the detection of fire, all staff have a panic alert and pager system which is checked regularly and will alert staff in the event of a fire. There are adequate numbers of staff available to evacuate residents in the event of fire. Deep sleep fire evacuations have been completed and the fire policy has been updated.

**Proposed Timescale:** 09/05/2017

**Theme:** Effective Services

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

The evacuation plans did not outline how to assist the residents to evacuate safely reflective of their assessed needs.

There was no centre emergency evacuation plan in place in all houses in the centre.

**11. Action Required:**

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

A further risk assessment of the service has been completed by a competent person. The service has upgraded the fire alarm system to enhance the detection of fire, all staff have now have torches, a panic alert and pager system which is checked regularly and will provide an additional alert to staff in the event of a fire. There are adequate numbers of staff available to evacuate residents in the event of fire by day and by night. Deep sleep fire evacuations have been completed with all residents in this centre, PEEPs have been updated for all individuals to reflect this and the fire policy has been updated which includes the updated plan.

**Proposed Timescale:** 19/12/2016

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Residents in all centres were not supported to buy, prepare and cook their own meals.

**12. Action Required:**

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

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

The remaining units in Centre Three are moving towards this model. Currently two of the 6 homes in this centre are effectively working with this model. A third home is planned to open with this model from 9th of January. A 4th house operates partially as a social care model and its full transition should be completed at the end of February 2017. The remaining two houses will have completed their transition by April 2017. The recruitment of new care assistants who are currently going through the recruitment process will assist with this process. The presence in the service of Social Care staff is assisting with this roll out. Catering, cleaning and laundry services are reducing in line with this process.

**Proposed Timescale:** 30/04/2017

**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:**

P.R.N. protocols were not signed by the relevant prescribing practitioner.

**13. Action Required:**

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

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

PRN Protocols will be put in place for each individual in the Designated Centre and will be signed off by the prescribing practitioner.

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

**Theme:** Health and Development

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

Assessments for self administering medication had not been completed for all residents in the centre.

**14. Action Required:**

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

Assessments for self administration of medications will be completed for each individual in the designated centre.

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

**Theme:** Health and Development

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

Medications that were stored for return to pharmacy had not been logged as required with internal procedures.

**15. Action Required:**

Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

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

A clear system for returning medications to pharmacy will be put in place in all areas of the Designated Centre.

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

**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 maximum capacity of the designated centre was not clearly outlined, inclusive of respite and residential residents.

**16. Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out 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.

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

This action has now been completed and the centre has clearly outlined the maximum capacity of the Centre in the Statement of Purpose, which included respite and residential residents.

**Proposed Timescale:** 19/12/2016

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

No annual review was complete at the time of inspection.

**17. Action Required:**

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

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

The Annual review is currently being completed and there will be a report on the Centre from January 1st 2016 until December 31st 2016.

**Proposed Timescale:** 14/02/2017

**Theme:** Leadership, Governance and Management

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

Staff were not receiving formal support throughout the designated centre at the time of inspection.

**18. 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:**

Senior and middle managers are currently receiving on-site training in Support and Supervision. Also 70 staff have completed information sessions on the subject. The CNME has supported the organisation with the process. In addition a policy on the process is being developed. This will commence for all staff and they will all have been through the process within the time scale.

**Proposed Timescale:** 30/04/2017

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

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

The provider has failed to review the overall needs of residents in the centre in line with their needs and supports required in line with the statement of purpose.

The provider had not ensured there was appropriate levels of staffing at all times to meet the needs of residents, training requirements were having an impact on frontline staffing.

**19. 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:**

The provider strives to ensure that there is always appropriate levels of familiar staff at all times to meet the needs of residents. The centre has some dependency on agency staff, but are currently going through a recruitment process for with care staff and social care workers. It is expected that this will guard against a reliance on agency provision. Ongoing training is high priority for the service and staff will be replaced to



eliminate any impact on frontline staff support provision.

**Proposed Timescale:** 19/12/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The provider failed to ensure that all staff had received mandatory training.

**20. 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:**

A full review of staff training is currently underway with trainers being booked to enable the completion of a training plan for the full year. This plan will reflect the health and social needs of the individual residents in addition to the mandatory training obligations.

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

**Theme:** Responsive Workforce

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

Staff were not receiving supervision as required.

**21. 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:**

On a daily basis there is a CNM2 or an acting manager on duty who works in a supernumery capacity. The role of this person is to supervise the staff on duty. A plan is now in place to ensure that there is replacement from senior acting staff, in the event of any CNM being on leave. The social care houses have Social Care Leaders and their role is to supervise the staff in the homes of the individuals living there. Also there is a CNM3 on duty on a Mon-Friday basis, who is also the PIC for the Centre. Eventually it is hoped that all houses will have Social Care Leaders. In addition formal Support and Supervision is being rolled out for all grades of staff.

**Proposed Timescale:** 31/05/2017

