Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Winterdown
Centre ID:	OSV-0005302
Centre county:	Kildare
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Shane Kenny
Lead inspector:	Jillian Connolly
Support inspector(s):	Helen Thompson
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
25 October 2016 10:30	25 October 2016 18:30

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

Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of the centre. This inspection was carried out following the receipt of unsolicited information and to monitor compliance with specific regulations.

How we gathered our evidence:
As part of this inspection, inspectors met with five residents. Inspectors also met with staff, observed practices and reviewed documentation such as residents' personal plans, health and safety documentation and audits. Residents, management and staff facilitated the inspection.

Description of the service:
The designated centre is one house located in Co. Kildare. The centre is registered for individuals over the age of 17. However based on the findings on the inspection, inspectors determined that the centre was no longer suitable to provide services to minors. Therefore following the inspection, the provider was invited to apply for a variation of their registration conditions, to ensure that no children could be admitted to the centre. Services were provided to male and female residents. The centre is operated by Nua Healthcare.

Overall findings:

The findings of this inspection substantiated the unsolicited information received by HIQA, which alleged an absence of appropriate risk management systems and the absence of appropriate healthcare. Overall inspectors found that:

- The systems in place for the management of risk did not protect residents or staff
- Inconsistency in staffing did not promote continuity of care for residents
- Staff did not have the appropriate knowledge and skills to ensure healthcare needs were met
- Positive behaviour support was not consistently provided to residents on a day to day basis

Management met with inspectors at the commencement of the inspection and acknowledged the deficits in the service. They provided inspectors with information on actions which were occurring to address the deficits and improve the quality of life for residents. Notwithstanding this, inspectors found that fundamentally, the service was not safe due to an overall failing by the provider to ensure that the governance and management systems in place were implemented effectively.

Within this report, the inspection findings are presented under the relevant outcome. The action plan at the end of the report sets out the failings identified during the inspection and the actions required by the provider to comply with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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 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):
No actions were required from the previous inspection.

Findings:
Inspectors did not inspect all aspects of this outcome; evidence presented is in respect of Regulation 26.

The centre had policies and procedures for the health and safety of residents, staff and visitors, inclusive of a risk management policy. There was a system in place for the overall review of risks within the centre. Individual risk assessments had also been completed for residents specific to their needs. There was also a system in place for the recording and reporting of adverse events. However, inspectors found that the systems were not effectively implemented in practice.

A review of the accident and incident reports demonstrated that the control measures identified in the risk assessments were not implemented in practice. For example, control measures included removing potentially harmful objects from the environment during incidents of challenging behaviour. However, recent incidences demonstrated that this measure was not consistently implemented.

There had also been 22 incidents in which staff had sustained an injury since the end of May 2016. A control measure identified was that staff could raise concerns in their monthly supervision meetings. This was not occurring in practice.

Inspectors determined that due to the frequency and severity of incidents, the systems in place for the assessment, management and response to risk were not effective.

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors did not inspect all aspects of this outcome and evidence presented is in respect of Regulation 7.

Residents in the centre required positive behaviour support, however inspectors found that the evidence did not support that all efforts had been consistently made to identify and alleviate the cause of residents' behaviours.

Inspectors found on a review of a personal plan that they did not adequately identify the needs of a resident and therefore the supports required to meet that need. Incident report forms demonstrated that 27 incidents had occurred since June 2016. The impact and duration of the incidents varied, with the longest recorded incident lasting 7 hours and 45 minutes. Physical restraint requiring two person holds was also recorded as being used on numerous occasions. In some instances the duration of the restraints lasted 7 minutes. Residents in the centre had expressed and demonstrated fear and dissatisfaction during and following the incidents. It was not clearly recorded if every effort was made to identify and alleviate the cause of the behaviour and what alternative measures had been considered prior to this intervention. Furthermore, it was not clear if the least restrictive procedure, for the shortest duration necessary, was used.

Supports provided included external appointments such as 'Mindology' and Psychiatry and the provision of a multi element support plan in place which identified proactive interventions and reactive interventions. However a review of incident records did not demonstrate that all efforts were made to ensure that the cause of the behaviour was identified and the least restrictive strategy utilised. For example, the centre had a policy in which 'Following an incident and at the most appropriate time staff should conduct a debrief with the service user'. This was not consistently occurring in practice.

Furthermore, a reactive strategy identified was the use of emotion cards. However the incident reports submitted to HIQA following the inspection, did not demonstrate that this intervention was used. Proactive strategies had also been identified in the most recent review of the positive behaviour support plan. The inspection occurred two weeks after this review and management confirmed that some of the proactive strategies had yet to be implemented, due to the absence of consistent staff. Records of adverse events also referenced previous incidents, however records of these incidents were not

submitted to HIQA.

Training records provided to HIQA demonstrated that regular staff had received training in management of aggression, breakaway techniques and physical restraint however they did not demonstrate that all staff on the roster had received this training. The provider subsequently submitted documentation stating that this training had been provided. However training records did not demonstrate that staff had received training in positive behaviour support relevant to the needs of the resident.

Judgment:
Non Compliant - Major

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:
A review of records demonstrated that not all incidents as required by Regulation 31 were notified to HIQA. Notification not reported to HIQA included an allegation of misconduct and unexplained absence.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
Inspectors did not inspect all aspects of this outcome and evidence presented is in respect of Regulation 6.

Inspectors found that residents had access to their General Practitioner (GP) and Allied Health Professionals such as Psychiatry and Palliative Care. However the evidence found on this inspection did not demonstrate that all necessary measures were taken to ensure that the healthcare needs of residents could be met within the centre.

A review of personal plan demonstrated that some healthcare needs had not been adequately assessed by an individual with the appropriate qualification. As a result the personal plan did not identify all the supports required. Furthermore assessments had not been reviewed or updated following a change in need. For example, records of a visit by the GP stated that there had been a change in the mobility status of one resident and they were at increased risk of falls. The mobility assessment of this resident had not been reviewed following this.

Inspectors also found that the timely and appropriate healthcare was not always provided to residents. For example, when a clinical indicator of the return of an illness had been identified, guidance from the appropriate healthcare professional had not been adhered to by staff. A personal plan had not been reviewed or updated following a resident returning to the centre following a stay in an acute setting.

Inspectors also found that the supports identified in personal plans were not always implemented in practice. For example, measures taken as a result of an identified need to restrict fluid intake were not always implemented. Fluid intake records were incomplete and in one instance, when the records were completed they demonstrated that the resident had consumed 50% more fluid than recommended in their personal plan.

Records also demonstrated conflicting opinions by healthcare professionals regarding care to be provided. There had been no forum in which the conflicting opinions were addressed by the healthcare professionals. Therefore due to the absence of a multi disciplinary approach to the care of the resident, it was not clear if the needs of the resident could be met within the designated centre.

An end of life care plan had been developed as required. However, inspectors found that the care plan did not adequately provide sufficient detail on the clinical care to be provided as the illness progressed. Management stated at the commencement of the inspection that staff had expressed that they did not have the appropriate knowledge to support some identified needs in the centre. Action had been taken to address this, including Allied Health Professionals attending team meetings to support staff with their concerns. However, inspectors found the personal plan of the resident did not identify the interventions required on a day to day basis to ensure that their needs were met. Therefore not providing the appropriate guidance to staff.

Judgment:
Non Compliant - Major

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:
The centre had policies and procedures in place for the ordering, prescribing, storing and administration of medication. Inspectors confirmed that medication was stored in a secure location within the centre.

The training records reviewed, demonstrated that regular staff had received training in the safe administration of medication. Prescription records demonstrated that they contained the appropriate information such as the name, address and date of birth of the resident. There was a signature of the prescriber for each individual medication. There was also a maximum dosage in a 24 hour period for p.r.n medication (as required). Administration records evidenced that medications were administered at the time prescribed. Staff showed inspectors the system used for recording the receipt of medication and the weekly checks conducted on p.r.n medication.

Inspectors found however that there was an absence of appropriate guidelines in place to support the administration of p.r.n medication including the administration of psychotropic medication for the management of anxiety and controlled drugs for pain management. For example, a pain assessment tool had not been completed to guide practice on when controlled drugs should be administered. Medication administration records demonstrated that different dosages had been administered by different staff however the rationale for the variances were not clear.

Inspectors also found that the controlled drugs register was not consistently signed by two staff at the commencement and conclusion of each shift as required by the organization’s policy.

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:
The person in charge had changed since the registration inspection. The person in charge met the requirements of Regulation 14. However, inspectors were informed at the commencement of the inspection that the person in charge was transitioning out of the post to another role within the organisation. As a result they were no longer full time in the centre. A review of rosters demonstrated that they were only present in the centre for two days in the month of October. Management informed inspectors that they were in the process of recruiting a person in charge on a full time basis for the centre. In the interim, two deputy team leaders from other designated centre had been attending the centre in the absence of the person in charge. However, the high level of non compliance on this inspection support the finding that this arrangement was not providing sufficient governance and oversight.

There had been a change to the management of the centre, and as of the day of the inspection the two persons participating in management as per the Health Act 2007 were the person in charge and the Chief Operating Officer (COO). However the organisation had an internal governance structure in place. The person in charge reported to the regional manager, who in turn reported to the Director of Operations. The Director of Operations reported to the COO. There were also additional supports such as Human Resources and a Clinical Team. However, inspectors found that the management structures did not ensure a safe and effective service was provided. Management met with inspectors at the commencement of the inspection and stated that they were aware of deficits in the service provided and had initiated measures to address same, the week prior to the inspection. This included the development of a draft quality improvement plan which was provided to inspectors. However a review of the draft quality improvement plan did not demonstrate that all deficits in practice had been identified and were in the process of being rectified. For example, deficits identified on medication management practices did not identify the variances in p.r.n medications. Furthermore it did not identify that the control measures identified in risk assessments were not being implemented in practice.

A review of the weekly reports submitted by the person in charge to the regional manager, also demonstrated that a number of issues had been identified months prior to the quality improvement plan being identified and had not been addressed, including the absence of staff supervision, inconsistency in staffing and numerous maintenance issues. Therefore inspectors determined that while action was occurring, there had been an unnecessary delay by the provider to respond to the deficits in service delivery.

Management confirmed that there had been no annual review of the quality and safety of care provided in the centre.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
A review of staff rosters demonstrated that the staffing provided to residents was as required. For example, if a resident required support by one member of staff, this was available. However, while there was a sufficient number of staff present, the rosters demonstrated that there was an absence of continuity of care to residents. In a four month period there had been 52 different individuals rostered to support residents. Considering the needs of residents, inspectors determined that this was an insufficient arrangement to ensure that residents were consistently supported.

Furthermore, a review of a sample of incident reports identified inconsistency in the rosters submitted to HIQA as a staff member who was documented as being present during an incident was not on the roster the date of the incident.

The training records provided to HIQA demonstrated that regular staff members had received mandatory training, the records provided were for 18 staff. However, inspectors were not assured that the staff employed in the centre had the knowledge and skill set to meet residents' needs, particularly their healthcare needs. This was confirmed by a review of the care provided to residents, and staff expressing concern of this to management. Nursing care was provided on an on call basis and once per week. However inspectors found that this was insufficient. As a result, inspectors requested that a review occur. The provider informed HIQA following the inspection that a registered nurse would be present in the centre for three hours a day going forward.

A deficit identified by management and inspectors was the absence of staff supervision. Inspectors were informed at the close of inspection that this would commence immediately.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0005302
Date of Inspection:	25 October 2016
Date of response:	19 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 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 systems in place for the management of risk did not reduce the risk of injury.

1. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated

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

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:
All staff have completed a refresher in MAPA (Management of Actual and Potential Aggression).
Environmental risk assessments were reviewed and updated.
Review of the system for management of risk in the centre to take place at weekly team meetings until all staff are proficient in the system.

Proposed Timescale: 01/02/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Records did not demonstrate that staff had the knowledge and skill set to support all residents.

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

Please state the actions you have taken or are planning to take:
Team meetings have been attended by Behaviour Specialist to upskill staff in supporting residents following updates to Multi-Element Behaviour Support Plan
Where Multi-Element Behaviour Support Plan is in place, it is reviewed regularly and discussed at weekly team meetings
Behavioural team visit the centre on a bi-weekly basis to support and upskill staff team in behaviours that challenge
Staff attended MAPA refresher training
Increased nursing hours in the centre and nurse attends weekly team meetings to upskill staff in supporting residents with healthcare needs
Nurse has completed training with staff on Fluid Intake Monitoring, Blood Pressure monitoring, Diabetes and Glucometer training, and Buccal Midazolam training
Autism training completed with the team by Senior Behaviour Specialist
Key-working training completed with the team
Individualised training tailored to specific residents needs was completed by Consultant Psychotherapist Dr. Margaret Wasz and Psychotherapist Ms. Ger Dunne
Pain management training to be completed on 3rd January 2017
Mental health awareness training to be completed on 16th January 2017

Proposed Timescale: 01/02/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Records did not demonstrate that all efforts were made to identify and alleviate the cause of behaviour.

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

Please state the actions you have taken or are planning to take:
Positive Behaviour Support Training to be completed with staff team on 16th January to ensure staff can identify and alleviate behaviours that challenge were appropriate.

Proposed Timescale: 01/02/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an allegation of misconduct against a staff member in the centre which HIQA had not been informed of.

4. Action Required:
Under Regulation 31 (1) (g) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation of misconduct by the registered provider or by staff.

Please state the actions you have taken or are planning to take:
NF07 notification submitted on 25th October 2016 and the investigation has since been closed out. Follow up report sent on 9th November 2016.
PIC/PPIM to review all incidents daily to identify notifiable events to the authority

Proposed Timescale: 19/12/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Appropriate healthcare was not provided.

5. 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:
Increase in nursing hours in the centre. Nurse is now in the centre 5 days per week to monitor healthcare needs of residents
Nurse has provided a range of training modules to the staff team at weekly team meetings to upskill staff in supporting residents' healthcare needs
There is ongoing psychiatric and psychotherapy support provided to all residents as required through Nua's clinical department
Falls assessment reviewed and updated for resident
End of Life Care Plan has been updated for the resident

Proposed Timescale: 19/12/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Referrals to Allied Health Professionals were not consistently occuring.

6. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
Referral to dietician completed for resident and dietician has completed a visit to the centre
Referral to Occupational Therapist completed for resident and recommendations implemented

Proposed Timescale: 19/12/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An end of life care plan did not adequately provide sufficient detail on the clinical care to be provided as an illness progressed.

7. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
End of Life Care Plan has been updated to include clinical care to be provided as illness progresses and will be reviewed on an ongoing basis

Proposed Timescale: 19/12/2016

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:
The practices regarding controlled drugs were not in line with the organization's policy. There was also inadequate guidelines for the administration of p.r.n medication.

8. Action Required:
Under Regulation 29 (4) (b) 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 medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Nurse has provided training on the management and administration of controlled drugs to all staff
Review of the guidelines for the administration of PRN medications in the centre to be completed

Proposed Timescale: 01/02/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge was no longer full time in the designated centre.

9. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
A new full time Person in Charge has been identified for the centre as a 0.5 WTE.

Proposed Timescale: 19/12/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems were not implemented effectively and therefore did not ensure a safe and effective service.

10. 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:
New 0.5 WTE PIC in place in the centre
Three PPIMs have been identified for the centre
Unannounced visits to the centre by senior management on a monthly basis
Senior management attending team meetings to ensure the implementation of management systems are adhered to

Proposed Timescale: 01/02/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care provided in the centre.

11. 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:
Annual review to be completed for the centre

Proposed Timescale: 01/03/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Nursing care was not provided as required.

12. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
Nursing staff in the centre Monday to Friday at present. This will be reviewed on an ongoing basis based on the needs of the residents.

Proposed Timescale: 19/12/2016

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of continuity of care for residents.

13. 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:
All roster gaps have been filled with full-time permanent staff and a designated relief panel has been updated for the centre to provide consistency for residents

Proposed Timescale: 19/12/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff members who were documented as being present during an incident were not on the roster for the date of the incident.

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

Please state the actions you have taken or are planning to take:
PIC/PPIM will update the roster as required to reflect any changes in staffing on an ongoing basis

Proposed Timescale: 19/12/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised.

15. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Staff supervision roster has been completed and supervision is being provided by PIC and deputy team leaders within the centre. The new deputy team leaders have been provided with supervision training. Supervision will be done on a monthly basis starting with the new team in December 2016.

Proposed Timescale: 30/12/2016