Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Earrach Services
Centre ID:	OSV-0005332
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ann Gilmartin
Lead inspector:	Catherine Glynn
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
08 March 2017 09:00	08 March 2017 18:00

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

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

Summary of findings from this inspection

Background to service

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

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

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

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

Standards).

How we gathered our evidence
The inspector met with 12 residents, five staff members and the person in charge during the inspection process. The inspector spent time with all twelve residents during the inspection. Not all residents were able to communicate with the inspector. The centre is situated on a campus setting and consists of two units and all units were visited by the inspector.

The inspector reviewed practices and documentation, including three residents' files, seven staff files, incident reports, policies and procedures, fire management related documents and risk assessments.

Description of the service
This centre is managed by the Health Service Executive (HSE) and is located outside Sligo town. The centre provides residential services for up to 12 people with an intellectual disability, who have been identified as requiring low to high levels of support. The service can accommodate male and female residents, from the age of 18 years upwards. The centre is located close to a town outside of Sligo and comprises of two units.

The person in charge had overall responsibility for the centre. The person in charge is supported in her role by the provider. The person in charge works directly in the centre, in an administrative capacity and regularly visits each unit to meet with staff and residents. All units are two storey dwellings and have a communal kitchen, dining room, lounge and bedroom spaces for residents.

Overall summary of findings
The centre had made some improvements since the last inspection in May 2016. However, inspectors found major non-compliance in four outcomes and moderate non-compliance in one outcome inspected. These outcomes relate to social care needs, health, safety and risk management, safeguarding and safety management, governance and management and workforce.

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

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
Overall, the inspector found that improvements were still required in the assessment and planning for residents' social care needs in the centre. An action from the previous inspection, to increase the staff support available to offer social care to residents, had not been implemented in line with the action plan time frame. This had been implemented mid February 2017; however, the inspector found that the allocation of this resource, to residents, was not always consistent with their plans.

Personal plans were reviewed as part of the inspection process. These plans outlined the care and support needs for each resident. There was evidence of engagement with representatives and relatives in the development of the personal plans; however, the inspector noted that there were gaps evident in some of the personal plans. For example, a recent admission did not reflect the change in service provision and supports required to meet the assessed needs of the resident.

Transition plans and compatibility assessments had not been completed for all of the residents as part of a robust admissions practice.

Residents' daily records were reviewed as part of the inspection, and the inspector found that there was limited examples or opportunities of residents actively engaging in their local community or social activities. Staff told the inspector that there was limited guidance or opportunities for residents to engage in active social roles with the required support from the designated centre. Staff also told the inspector that the service was not offering residents choices in how to meet their assessed social care needs.

At the time of inspection, there was one vehicle allocated to the centre which did not adequately meet the needs of the twelve residents.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The inspector found that actions from the previous inspection had not been completed within the identified timeframes. For example, the systems in place for the assessment and management of risk remained inadequate. In addition, the person in charge had not adhered to the organisation's policy regarding the on-going monitoring and review of risks identified in the centre. For example, the risk register held in the centre, did not reflect an understanding of the outcomes of the assessed risks. The inspector found that there were gaps in practice, regarding the hazards identified. Where control measures were outlined, the risk rating remained high regardless of control measures in place.

There was a system in place for the on-going recording and review of incidents that occurred in the centre; however, the inspector noted that the person in charge had not sufficiently implemented these systems, as required by the organisation.

The inspector found that fire drills had occurred in the centre; however, the information recorded was limited. While the number of residents participating in the drills and the time to complete the evacuation were recorded, they did not outline if staff had implemented the horizontal evacuation procedure in the centre. The inspector noted that a resident who could not evacuate had no clear plan or strategy in place to support them in the event of an emergency. The inspector was advised that the local fire department were alerted to this issue; however, the person in charge and provider had not clearly outlined or identified, how to evacuate the resident in the event of a fire.

Staff informed the inspector about the drills which had been completed and understood the evacuation procedure as an individual process within each house. The inspector noted that a whistle was used to alert residents to a fire in the centre, this did not allow residents the opportunity to become familiar and to recognise the sound of the alarm system.

Inconsistent practices throughout the centre were noted by the inspector. For example, measures that were implemented for the use and maintenance of a dryer in one house were not implemented in the other house in the centre.

Service records for transport were not held in the centre, the inspector found that they were held by the garage that the service contract was with. The person in charge did not have a history of regular checks or an outline of all work completed in the centre, at the time of inspection. The safety statement was dated 2015 and listed management supports that were no longer in place at the centre. The inspector found that the annual environmental safety checks had not been completed since January 2016.

Infection control measures had not been fully implemented in both houses in the centre. The inspector noted that the systems required, as set out by the organisation, were not in place and guidelines had not been fully implemented.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
There were policies and procedures in place for the safeguarding of vulnerable adults in the centre. There were photographs of the designated officer, the complaints officer and the external person for dealing with any issues or concerns on display in each house, .

On review of incidents, there were no allegations or suspicions of abuse in the centre. Some of the resident's told the inspector that they felt safe in their home. The inspector observed that the staff treated residents with respect and were observed to respect the privacy of residents during the course of the inspection.

The inspector reviewed training records and found that staff had not completed training in all requirements of safeguarding procedures, in line with the national policy.

Restrictive practice was reviewed during the inspection and the inspector found that

there were practices in place that were monitored and reviewed to meet the care and support needs for residents. A robust multidisciplinary team process ensured behaviour support plans were in place and guidance had been provided regarding restrictive practices that were in use in the centre. Staff were trained in the management of behaviours that challenge in the centre. The inspector noted that there were continuous reviews and access to a psychiatrist and clinical nurse specialists, where required, to monitor and guide practice.

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

Findings:
Actions from the previous inspection remained outstanding on the day of inspection. These actions related to the absence of safe systems, completion of the annual review of the quality and safety of care and consultation with residents and families.

The inspector found that the annual review of the quality and safety of care had not been completed at the time of inspection.

A six month unannounced audit was completed on the 2 of February 2017, however this included details of another designated centre in the final report. The visit was completed by the head of social care and a quality and safety coordinator. This report did not clearly identify the actions required by each centre detailed in the report. In addition, there was a lack of clarity regarding the actions required and there had been no update to the status of the actions, since the report was completed. The report identified the need to stabilise the staff teams in the two houses in the centre; however, it did not outline how this was going to be addressed.

The inspector spoke with the provider on the day of inspection regarding the concerns about the inconsistent staffing in the centre. Several documents were provided to the inspector reflecting correspondence within the management structures. These staffing

issues had been identified in a recent quality improvement plan and the six month unannounced report; however, no clear plan had been outlined to address these. Following discussion with the provider, staffing supports were provided as a temporary solution from other areas of the service.

On review of documentation the inspector found that there was no evidence of supervision provided to the person in charge. The person in charge had not commenced supervision for staff working in the centre at the time of inspection.

The management structure in the centre was not effective. While there was knowledge of areas of concern; there was a lack of completion of outstanding tasks as identified in the quality improvement plan, the previous HIQA inspection report and a failure to ensure effective management systems were implemented in the centre. For example, the provider had a system for the recording and monitoring of incidents; however, incidents in the centre had not been uploaded to the system to enable the effective review and monitoring of incidents in the centre.

There was an active quality improvement plan in place for the centre, which was monitored on a weekly basis. The person in charge was required to provide a weekly update to this team. However, on the day of inspection, the inspector noted that the person in charge had missed the most recent review deadline. There were 43 actions identified in the plan and twenty one of these actions were noted by the inspector to be overdue The previous HIQA inspection report had identified ten actions and the inspector found that eight of the actions had not been completed on the day of inspection.

On review of the person in charge's staff file, the inspector found that all documents were not obtained in line with schedule two of the regulations.

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

Findings:
Actions from the previous inspection report remained outstanding in relation to staff supervision and the skill mix and allocation of appropriate resources.

Five staff files were reviewed as part of the inspection, including the person in charge, staff nurses, care staff and agency staff. The inspector found that these were in not in line with the requirements of schedule 2. The inspector found that the person in charge had also conducted an audit which identified gaps and the findings from this audit had not been addressed at the time of inspection.

There was a planned and actual rota available for review. While measures had been put in place to address the lack of required resources for both houses in the centre, these had been affected by an adjoining designated centre under the management of the person in charge. The inspector found that the staffing resources in the two designated centres were shared and this had an impact on the service provided, for all of the residents. The staff numbers allocated to the centre did not reflect the statement of purpose.

On review of staffing rosters, the inspector found that there were inconsistencies in staffing provided for the residents. This did not ensure consistency of care and support needs for the residents'. The inspector had spoken with the provider regarding the level of inconsistency and the failure to address on-going staffing issues, this resulted in temporary staff being provided on the day of inspection to ensure the required skill mix and staffing requirements were in place. However the inspector noted that this was also an action identified in a recent HSE quality improvement plan.

Formal supervision had not commenced in the designated centre for all staff at the time of inspection. The inspector reviewed staff meetings and identified that there had been two meetings since person in charge joined the centre in May 2016. This did not provide staff with effective guidance or support systems in the centre and did not provide the opportunity for staff to raise concerns or discuss practice within the centre.

A review of daily records identified that there continued to be a lack of staffing support provided to residents to enable them to engage in social opportunities. Additional staffing support had been introduced at the end of February 2017, to provide additional support hours to all twelve residents each week. This was based on a 39 hour roster and reflected the centre's planned staff roster. Resident's were not supported to engage in social supports outside of the hours planned in the staff roster and there were days identified where there was no opportunity for the active participation in social goals, which reflected residents' choice. This was further impacted upon by some residents required 2 members of staff when accessing the local community. The inspector noted that this house had not been included in a recent report regarding the skill mix and numbers of staff required for services.

Rosters reflected inconsistent staffing on the day of inspection. Resident's and families had also identified inconsistent staffing as causing confusion and distress for all of the residents. For example, the nursing staff allocated to one house had been required to provide further support to both houses and a third house in another designated centre to ensure that nursing care needs were attended to. Two active complaints reflected the

issues about inconsistent staffing and lack of consultation regarding placements for residents.

Staff on duty on the day of inspection, outlined the challenges they faced to provide care that was not a basic service. Staff were required to provide direct support to residents, complete administration tasks and attend to household cleaning duties. This further prevented the resident's opportunity to engage in activities in line with their interests.

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:

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[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005332
Date of Inspection:	08 March 2017
Date of response:	19 April 2017

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that the personal plans reflected changes in service provided and the assessed needs of residents.

1. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the

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

resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

Please state the actions you have taken or are planning to take:
The person in charge has ensured a personal plan that reflects the residents assessed needs has been developed on 5/04/17 for a resident who was admitted.

Proposed Timescale: 05/04/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure;

1. that a comprehensive compatibility assessment was completed for all residents in the centre, when admission's had occurred.
2. the allocation of resources had not been reviewed with regard to transport available for all residents in the centre to achieve social goals.

2. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
1. The person in charge has ensured that compatibility assessments have been completed with each resident. Completed on 14/04/17
2. The person in charge has conducted a review of all available transport within the locality. The PIC will ensure that transport is available to include service based transport and public transport to support residents to achieve their social goals. Access to an additional service based vehicle will be made available by 19/05/17

Proposed Timescale: 19/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to put measures in place to support all of the residents' to meet their assessed needs in the centre.

3. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
• The provider is currently undertaking a staffing review to determine the number and

skill mix of the staff teams required to meet the assessed needs of residents in the designated centre.
• The PIC has conducted a review of the rostering of staff and changes have been made to ensure the off duty meets the assessed needs of residents to achieve their social goals. Completed on 14/03/17
• One staff previously supplied from an agency has converted to become a fulltime HSE staff. 31/03/17
• The Provider has ensured that one staff who is due to retire has been granted an additional years employment.10/04/17

Proposed Timescale: 17/05/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured the on-going review of risk and learning from incidents was completed in the centre.

The health and safety statement had not been updated since 2015. The plan did not reflect the current management structures and the supports provided to assist in the event of emergencies.

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

Please state the actions you have taken or are planning to take:
• The Provider has ensured that a system is now in place for the assessment, management and on-going review of risk and incidents. Management will be in attendance at the monthly meetings to monitor and ensure on-going review of risk and the shared learning from incidents in the centre. Completed on 05/04/17
• The Health & Safety Statement has now been updated. A new health & safety system has been introduced across all areas in the designated centre. The new safety statement now reflects the current management structures and supports provided in the event of emergencies. Completed on 31/03/17

Proposed Timescale: 05/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Infection control measures had not been fully implemented throughout the designated

centre, in line with local and nationally policy.

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

Please state the actions you have taken or are planning to take:
• Cleaning schedules have been reviewed and are now being actively monitored on a daily basis by the PIC. Completed on 31/03/17
• Infection control audits have commenced within the designated centre and will be monitored by the PIC. The PIC has ensured that following completion of the audits, action plans are developed. Re-audits will be completed. Learning from the audits was shared at the Governance for Quality & Safety meetings on 12/04/17 and at monthly meetings after that.
• Infection control Nurse Specialist will be requested to provide training and support to staff. This will be delivered on 28/04/17

Proposed Timescale: 28/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire management systems were inconsistently implemented throughout the centre; as reflected in the use and maintenance of the laundry facilities, the response to fire drills and the use of a whistle to alert residents to fire alarms.

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

Please state the actions you have taken or are planning to take:
• The system for use and maintenance of the laundry facilities has been reviewed by the PIC. A system is now in place to ensure compliance with fire safety management systems. Completed on 13/03/17
• The PIC will ensure that the practice of using a whistle as part of the fire drills has ceased. The PIC will ensure that documentation has been reviewed to reflect the use of the fire alarm during fire drills. Completed on 13/03/17
• New fire evacuation schedules have been developed and circulated within the designated centre. The PIC has also communicated with staff regarding the new schedules and will ensure they are carried out as scheduled. Completed on 5/04/17
• Fire safety training has taken place on 29/03/17. Additional fire safety training will be provided 13/04/17

Proposed Timescale: 13/04/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents personal evacuation plans did not address when residents refused to leave the centre.

7. 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:
All residents PEEPS have been reviewed to ensure there is a clear direction on how to evacuate in the event of a fire including the resident who refused to leave the centre. Completed on 07/04/17

Proposed Timescale: 07/04/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not ensured that all staff had completed all training in safeguarding in line with the national policy of the organisation.

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

Please state the actions you have taken or are planning to take:
• The PIC has ensured that all staff have now completed training in safeguarding in line with the national policy. Completed on 04/04/17
• The PIC has developed a staff training database to ensure that all mandatory training is maintained up to date. Completed on 04/04/17

Proposed Timescale: 04/04/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The provider had not ensured that the documents as required by schedule two were obtained in respect of the person in charge.

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

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

Proposed Timescale: 16/06/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that residents and relatives had access to the unannounced visit report.

10. Action Required:
Under Regulation 23 (2) (b) you are required to: Maintain a copy of the report of the unannounced visit to the designated centre and make it available on request to residents and their representatives and the chief inspector.

Please state the actions you have taken or are planning to take:
A copy of the unannounced visit has been completed and is available to residents and their representatives upon request. A letter advising families of same will be been sent before 27/04/17.

Proposed Timescale: 27/04/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that the annual review of the quality and safety of care was completed for the centre and that it reflected consultation with families or representatives of the residents in the centre.

11. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
The Provider Nominee has completed the annual review of the quality and safety of care and support in the centre. This review includes consultation with resident's and families. A copy of this review will be available to residents, their families and staff. The Provider Nominee will submit a copy to the authority before 27/04/17

Proposed Timescale: 27/04/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to provide a document reflecting the six month unannounced visit of this centre that did not include another designated centre in the findings. In addition, the provider failed to ensure that the actions identified from the report were implemented.

12. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
• The Provider Nominee has completed a 6 monthly unannounced visit and a report has been prepared for this designated centre. Completed on 17/04/17
• The actions from the 6 monthly visits identified from the report will be submitted to the Provider and actively monitored by the senior management team on a weekly basis as part of the existing QIP. Completed on 17/04/17

Proposed Timescale: 27/04/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure the systems in place in the designated centre were effectively monitored and were appropriate to the needs of all residents.

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

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

• The Provider has appointed a CNM 3 to strengthen the governance and management of the centre. Completed on 13/03/17
• The Provider will ensure that, in future, in the PIC's absence an nominated staff will submit the QIP to the Provider Nominee on a weekly basis. Completed on 13/03/17
• An on-call out of hours has been approved and commenced. Completed on 30/03/17
• The PIC has put a system in place to ensure that all incidents and complaints are monitored and managed according to the organisations local policies. Completed on 30/03/17
• All staff members are up to date with the mandatory safeguarding training Completed on 05/04/17
• Annual review for quality & safety has been completed inclusive of consultation with residents and their families. The Provider Nominee - 27/04/17

Proposed Timescale: 27/04/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not ensured that all information as required by schedule two for all staff, was held and maintained in the designated centre.

14. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
All personnel files are now stored in the designated centre and the PIC will ensure that all documents required by schedule 2 are in place by 05/05/17

Proposed Timescale: 05/05/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not completed as assessment of the overall number of staffing required based on the assessed needs of all residents in the centre, in line with the statement of purpose.

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

Please state the actions you have taken or are planning to take:
• The provider is currently undertaking a staffing review to determine the number and skill mix of the staff teams required to meet the assessed needs of residents in the designated centre.
• Additional resource hours have been allocated to meet the social goals of residents and this will commence by 01/05/17

Proposed Timescale: 17/05/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to ensure that effective resources were allocated to the designated centre to maintain the continuity of care and support for all residents.

16. 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:
• The provider is currently undertaking a staffing review to determine the number and skill mix of the staff teams required to meet the assessed needs of residents in the designated centre.
• The PIC has conducted a review of the rostering of staff and changes have been made to ensure the off duty meets the assessed needs of residents to achieve their social goals. Completed on 14/03/17
• One staff previously supplied from an agency has converted to become a fulltime HSE staff. 31/03/17
• The Provider has ensured that one staff who is due to retire has been granted an additional years employment.10/04/17
• The PIC has consulted with the local agency and secured a consistent panel of staff 30/03/17
• Additional resource hours have been allocated to meet the social goals of residents and this will commence by 01/05/17

Proposed Timescale: 17/05/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that based on residents assessed needs, the appropriate staffing was provided in a consistent manner.

17. 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:
The Provider will ensure that the appropriate nursing staff based on the assessed needs of residents has been rostered in accordance with the statement of purpose and will be in place by 01/05/17

Proposed Timescale: 01/05/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure supervision was provided to all staff working in the centre.

18. 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:
• Supervision of staff has commenced and a schedule of dates for all staff working in the designated centre has been developed by the PIC. Completed on 05/04/17
• All staff have been informed through written communication advising them of the supervision schedule. The schedule has been provided to staff by the PIC. 05/04/17
• Training in supervision of staff has been made available to staff through HSE land. Completed on 11/04/17

Proposed Timescale: 11/04/2017