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:	Teresa Dykes
Lead inspector:	Jillian Connolly
Support inspector(s):	Stevan Orme
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:
06 May 2016 09:00	06 May 2016 17:30

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 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 inspection was carried out to monitor compliance with the regulations and standards. The centre had previously been inspected in January 2015. At that time it was two houses as part of a larger centre. Following that inspection, the provider re structured the wider service. This resulted in these two houses becoming one standalone designated centre.

How we gathered our evidence

As part of this inspection, the inspector spent time with 12 residents and observed residents to be comfortable within their home and familiar with staff. The inspector also met with staff, observed practices and reviewed documentation such as residents' personal plans, health and safety documentation and audits. Management and staff facilitated the inspection.

Description of the service

The centre is two houses located on the outskirts of a town. The centre accommodated twelve residents on a full-time basis; six residents lived in each house. Each resident had their own bedroom which was suitable in size to meet residents' needs with sufficient storage space for all personal belongings. The provider had produced a document called the Statement of Purpose, as required by the regulations. This document aims to describe the service provided. The inspector

found that the overall findings of this inspection demonstrated that the provider was not providing the service, as described.

Overall findings
Staff were observed to engage with residents in a dignified and respectful manner. Residents told inspectors that they were happy with their home and the staff that supported them. However, the inspector found that there was an absence of appropriate supports in place to ensure that the service was safe and effective. This resulted in an absence of the following:
- Opportunities for residents to achieve their personal goals
- Appropriate health and safety precautions
- Review of the quality and safety of care provided
- Sufficient staffing
- Staff supervision

The reasons for these findings are explained at the end of the report and the regulations that were not met 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 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
In January 2015 inspectors found that residents' personal goals were not clearly identified. The provider had responded by stating that the personal care plans for all residents would be reviewed and goals up dated by May 2015. On this inspection, inspectors reviewed a sample of personal plans and confirmed that personal care plans had been updated following the last inspection.

Each resident had an assessment in place of their health and social care needs. Following on from this a plan of care was created. Residents also had a person centred plan in place which identified goals which they would like to achieve. Goals were presented in an accessible format using photographs. Residents gave inspectors permission to look through their personal plans. Inspectors found that in the main goals were short term, once off activities as opposed to promoting skill building and personal development. For example, goals included going on an overnight stay in a hotel or going to a concert. In some instances, it was clear that residents had been supported to achieve their goals and expressed to inspectors that they enjoyed the activity. In other instances, goals had not been achieved and had been carried over from the year previous. Inspectors found that the reason for goals not being achieved had not been accounted for in the review of the residents' plans. Therefore the effectiveness of the plan had not been identified. The supports residents also required to achieve personal goals were also absent.

Personal plans also identified activities that residents would like to complete every month. These were reviewed on a monthly basis by the resident's named staff and the resident. Inspectors found that in some instances the activities did not occur. The

reason for this was not identified.

Residents' family members were invited to attend an annual meeting.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There were policies and procedures in place for the health and safety of residents, staff and visitors. A finding from the previous inspection was that the risk management policy was not centre specific. The provider responded by stating that this would be addressed by May 2015. Management confirmed on this inspection, this had yet to occur.

There were systems in place for the assessment and management of risk. However, inspectors found that the systems were not consistently implemented in practice. Environmental, clinical and operational risks had been identified in the centre and control measures were identified. However, inspectors were not assured of the validity of the control measures as they did not relate to the hazards identified.

For example, a risk assessment had been conducted for client safety. The hazards identified in the document were:
- inadequate supervision of residents due to staffing
- residents 'wandering'
- residents not having the ability to choose the activity that they would like to take part in.

However, the control measures identified were:
- staff had received training in the safeguarding of vulnerable adults
- staff to raise awareness of residents' safety with residents and asking callers to the door for identification.

None of which relate to the actual hazards identified as staffing levels were not addressed, residents' being at risk of wandering was not addressed and activities were not addressed.

Risk assessments had also been created for individual residents. In some instances, inspectors found that relevant control measures had been identified such as residents who were at risk of choking. However, in other instances the assessments were not effective. For example, not all residents who were at risk of falls had been identified and therefore the necessary control measures had not been put in place. Inspectors requested that the provider complete a review immediately following the inspection and provide assurances to HIQA that all necessary measures were in place to safeguard residents. This occurred and the provider confirmed that residents were safe.

In January 2015, inspectors identified that staff had not been provided with training in completing risk assessments. The provider stated that this would occur in April 2015. This had not occurred.

Personal alarms had been provided to residents to alert staff at night as stated in the action plan of the January 2015 inspection.

There were inadequate fire safety management systems in place at the time of the previous inspection. The provider responded by stating that house specific fire evacuation plans would be created. Inspectors found that this had occurred. However, the plan conflicted with the narrative provided to inspectors by staff and the record of fire drills.

The two houses in the centre were interconnected. There was also a third house which was under a separate governance structure. All three houses were interconnected by a door and the fire alarm was connected in all three houses. Inspectors found that there was confusion in regards to the procedure to be followed in the event of a fire which resulted in an unnecessary risk. For example, staff stated that the procedure was for each house to support each other in the event of a fire and that residents would be evacuated into the adjoining house, particularly residents on the first floor. This had not been simulated in a fire drill.

A fire drill had been conducted the previous week involving all three houses. However, all three houses had been evacuated. This conflicted with what inspectors were told by staff. The evacuation plan for the centre did not account for either scenario as there was an absence of reference to the neighbouring house. Fire drills pertinent to each house demonstrated that residents could be evacuated within an appropriate time frame from each individual house.

Each resident had an individual personal emergency evacuation plan which identified the supports that they would require in the event of an emergency. Inspectors observed that the building was provided with appropriate fire fighting equipment and precautions including fire doors, automatic self closers, fire extinguishers, emergency lighting and signage. Records demonstrated that these were serviced at appropriate intervals.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
There were policies and procedures in place for the safeguarding of vulnerable adults. Staff had received training in this and communicated with inspectors the action that they would take in the event of an allegation or suspicion of abuse. There were no allegations or suspicions of abuse in the centre since the last inspection. Residents told inspectors that they liked their home and that they felt safe. In January 2015, inspectors found that not all staff employed in the centre had garda clearance. As the records were maintained in a central office, the provider confirmed in writing to HIQA on the day of this inspection that this had been obtained for all staff.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that residents were supported to access health care professionals as required and in line with their personal plan. This was evident from speaking to residents, staff and a review of personal plans.

Following an assessment of residents' health care needs, a plan of care was created by nursing staff if a need was identified. Inspectors found that the plans of care were clear and provided appropriate guidance of the supports residents required to ensure that

their health care needs were met. However, inspectors identified instances in which the plan of care was not implemented and there was no rationale recorded. For example, a plan of care stated that a resident required support to monitor their weight on a monthly basis. This had not occurred for two months.

Inspectors spoke to residents and staff about mealtimes. Residents told inspectors that the menu was planned for the week ahead as a group. Once the menu was decided, residents went to the supermarket with staff to complete the weekly shop. Some residents were involved in the preparation of food, in line with their choice. A review of weekly menus and discussions with staff evidenced that healthy eating was promoted within the centre.

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):
No actions were required from the previous inspection.

Findings:
There were centre specific procedures in place for the prescribing, administrating, recording and storage of medicines. Inspectors confirmed that medicines were stored securely. Each resident had been assessed for the ability to manage their own medicines. Inspectors observed that the practice in the centre was for residents to be actively involved in the administration of their own medicines with the support of staff. All staff had received medication management training.

Of the sample of prescription records reviewed, inspectors confirmed that they contained all of the relevant information, including the name, date of birth and address of residents. There was also a photo of the resident. The maximum dosage was also in place for PRN medicines (a medicine only to be taken as the need arises). A review of a sample of medicine administration records confirmed that the times of administration correlated with the times prescribed. There was also a signature in place for the supervising staff.

The centre had a stock control system in place and medication audits occurred. There was also a monitoring system in place for the monitoring of residents' use of antibiotics.

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

Findings:
Ineffective management systems were identified on the inspection in January 2015. The provider responded by identifying a person in charge and stating that regular meetings would occur going forward. As of the day of this inspection, the person in charge was absent from the centre for more than 28 days. HIQA had been notified of this as required by regulation 32. A person had been nominated to conduct the role of the person in charge in their absence. The individual was present to facilitate the inspection. They demonstrated that they had knowledge of the legislation and their statutory responsibilities. They also had the appropriate qualifications and experience to fulfil the role. However, the inspector found that due to the person's role within the wider organization they were not in a position to ensure that the statutory responsibility of the person in charge was met. They stated that they were not a regular presence in the centre and tried to attend the centre on a monthly basis. Therefore inspectors determined that this arrangement was not effective.

The absence of the person in charge was evident in the findings of this inspection. The primary responsibility of the day to day running of the centre was assigned to the staff on duty. Medication audits were the only regular reviews of the quality and safety of care conducted in the centre. A health and safety audit had been conducted in February 2016. At that time it was identified that the windows in the house required cleaning. Inspectors observed the windows to be dirty as of this inspection. Staff confirmed that this had not occurred.

Quality and safety meetings had been commenced in November 2015 at an organizational level which aimed to improve the service provided. Inspectors found that the meetings did not directly address the deficits in service delivery in this centre and were primarily focused on a regional level. Therefore considering the findings of this inspection the direct impact and effectiveness of those meetings on this centre were inadequate.

An annual review of the quality of safety of care was given to the inspector. The annual review comprised of statements. These statements were not supported by evidence. Therefore the document was not a review of the quality and safety of care provided in the service as required by regulation. There had also been no unannounced visit completed by the provider as required by Regulation 23. The inspectors also found that residents and/or their representatives had not been included in the review.

Following the inspection, HIQA informed the provider of the deficits identified with the governance and management of the centre. The provider assured the Chief Inspector that this would be reviewed and more robust arrangements implemented.

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:
In January 2015, inspectors identified that there were insufficient staff to care and support the twelve residents. This resulted in residents usually going out in groups to participate in social activities. The provider had responded to this failing by stating that an additional 39 hours of social support hours would be allocated to the centre. Inspectors found on this inspection that the staffing of the centre was the same as in January 2015. Staff informed inspectors that there had been additional staff available for a short period of time however due to an absence of appropriate resources in other parts of the organization, this had not been maintained. A review of rosters demonstrated that the standard staffing compliment was two staff to support twelve residents, one staff per house.

A review of daily records and speaking with residents and staff, demonstrated to inspectors that this staffing level was insufficient. Residents continued to attend activities as a large group and this impacted on their opportunities to achieve their personal goals. An example of a weekly activity was that for all six residents in one house to attend the local supermarket at the same time. This reduced residents'

opportunities for independence and autonomy. Furthermore, the communication diary demonstrated that one resident had to move to another house for the weekend as their peers were temporarily absent and staff had not been allocated to support that resident to remain in their own home.

The actual number of staff employed in the centre was insufficient to ensure that a regular member of staff was on duty at all times. Therefore support staff was regularly obtained from other centres.

Inspectors also observed staff to complete all tasks within each of the houses, including direct support to residents, administration tasks and housekeeping tasks. The volume of tasks to be completed clearly prevented residents having the opportunity to engage in activities in line with their interests.

Inspectors reviewed the training records for staff which were maintained in the centre and identified deficits. However, the provider submitted written confirmation to HIQA to state that all staff had the relevant mandatory training as required by regulation.

There was no formal staff supervision in place as of the day of inspection. The inspector was informed that this was due to commence once management had received training. However, in the interim, due to the absence of management in the centre there was an absence of informal supervision. Management informed inspectors that the organization had a forum for staff meetings which involved all designated centres. The aim of these meetings were to ensure that staff were supported by management. Inspectors reviewed minutes of these meetings and found that staff members from this centre had only attended once. Therefore inspectors determined that this was an ineffective forum for communication between management and staff.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	Earrach Services
Centre ID:	OSV-0005332
Date of Inspection:	06 May 2016
Date of response:	11 August 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Goals were carried over from previous years, there was no reason provided for this.

The effectiveness of the plan had also not been reviewed.

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

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

Please state the actions you have taken or are planning to take:
• The PIC will ensure that personal goals will incorporate promotion of skill building and personal development in relation to individuals choices and preferences.
• Achievable goals will be identified with the resident, supports required will be outlined, and an evaluation of the goal following achievement/non-achievement will follow.
• Personal Plans will be reviewed on a regular basis to ensure effectiveness.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not promote the personal development of residents.

Personal plans did not identify the supports residents required to achieve their goals.

2. Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
• The PIC will ensure that personal goals will incorporate promotion of skill building and personal development in relation to individual's choices and preferences.
• Achievable goals will be identified, supports required will be outlined, and an evaluation of the goal following achievement/non-achievement will follow.
• Personal Plans will be reviewed on a regular basis to ensure effectiveness.

Proposed Timescale: 30/09/2016

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 assessment and management of risk were not adequate.

3. 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 system in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies will be reviewed to ensure effectiveness. This will be monitored on a regular basis following review by the Person in Charge.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not clear the procedure to be followed in the event of a fire.

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

Please state the actions you have taken or are planning to take:
• Following the fire officer visiting the premises on a number of occasions in June 2016, a 3 house planned evacuation was conducted under the supervision of the fire officer, Estates Dept, HSE.
• An evacuation plan has been put in place and shared with the 3 houses to ensure a clear procedure to be followed in the event of a fire. This is available to all staff.
• Planned evacuations will be carried out on a monthly basis, day and night and will capture times of minimum staffing. This will be reviewed if circumstances change. Documented minutes and learning from the planned evacuation will be available to all staff. The Person in Charge will ensure same.

Proposed Timescale: 31/07/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors identified instances in which the plan of care of a resident was not consistently implemented in practice.

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:
• All staff will ensure that the plan of care of all residents will be consistently implemented in practice.
• Residents requiring support to monitor their weight will be assisted by staff as per care plan.

Proposed Timescale: 31/07/2016

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:
The management structure in the absence of the person in charge was ineffective.

6. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
• An Acting PIC has been identified for this centre and is in position since May 16th 2016.
• PIC paperwork will be submitted to the Authority by September 1st 2016.
• The management structure has been reviewed to identify clear lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Proposed Timescale: 01/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of systems in place to ensure the service provided was safe and effective.

7. 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:
• An Acting PIC has been identified for this centre and is in position since May 16th 2016.
• PIC paperwork will be submitted to the Authority by September 1st 2016.
• The management structure has been reviewed to identify clear lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.
• Systems have been reviewed to ensure the service provided is safe and effective

Proposed Timescale: 01/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review of the quality and safety of care was not reflective of the practice of the centre.

8. 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:
An acting PIC has been identified for this centre and is in position since May 16th 2016. PIC paperwork will be submitted to the authority by September 1st 2016.

Windows which required cleaning have been completed and this will occur regularly or as needed.

Quality and safety will be a standing agenda at the monthly unit meetings. Any issues of concern will be escalated to organisational level.

An unannounced visit will be conducted by the provider in line with Regulation 23.

Families and residents will be consulted with and invited to reviews in relation to their relative. Documentation will be available in relation to this on the resident's personal plan.

An audit schedule will be developed for the centre to ensure meaningful audits are implemented on a consistent basis.

An Annual review of the quality and safety of care and support in the designated centre will be undertaken by the PIC. The annual review of the quality and safety of care will assess the performance of the centre against the national standards.

Proposed Timescale: 31/10/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The review did not involve consultation with residents and/or their families.

9. Action Required:
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
• PIC will ensure that Residents and Family members are invited to attend review meetings; there will be evidence of this on residents' personal files.
• Residents will be consulted with for their views and comments through a regular feedback forum. Actions will be developed from this forum

Proposed Timescale: 30/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not conducted an unannounced visit.

10. 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 will ensure that an unannounced visit will be conducted by the Provider or a nominee in line with Regulation 23.

A schedule will be developed of unannounced visits.

HIQA non compliance will be discussed

Incidents, complaints and safeguarding will be reviewed on a monthly basis. An audit, action plan and re-audit will be completed.

Residents and families will be invited to give feedback on the existing services and any improvements they wish to see.

Proposed Timescale: 31/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient staf employed in the centre to ensure residents were supported by the same staff throughout the year.

Furthermore the staff allocated to the centre did not promote residents independence and autonomy.

11. 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 staff roster will be organised to ensure that residents are supported and have opportunities for independence and autonomy and achieve their personal goals
●An extra 39 hour social work support will be put in place to facilitate a person centred approach in care.
● The practice of residents having to leave their accommodation and be supported in another home at holiday times has ceased.
● The PIC will undergo supervision with the line manager
● A schedule of supervision will be developed by the PIC for all staff within the centre..

Proposed Timescale: 30/09/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an absence of staff supervision.

12. 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:
• The PIC will develop a schedule of supervision for all staff within the centre.
• The PIC will undergo a supervision meeting with line manager to agree goals in line with the PIC role

Proposed Timescale: 30/09/2016