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:	Ballytrim House
Centre ID:	OSV-0002523
Centre county:	Donegal
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Jacinta Lyons
Lead inspector:	Stevan Orme
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
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:
30 May 2017 09:10	30 May 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 the inspection:
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:
During the inspection, the inspector met with seven residents who lived at the centre and four staff members. The inspector spoke the centre's person in charge and Area Coordinator. In addition, the inspector reviewed documents such as personal plans, fire safety records, risk assessments, safeguarding plans, rosters, policies and procedures and staff personnel files.

Description of the service:
The provider had produced a document called the statement of purpose, as required by the regulations and the inspector found that the service was being provided as described. The centre was part of services provided by the Health Service Executive (HSE) in Donegal. The centre comprised of a large house in a small rural town with nearby access to local amenities. The centre provided 12 full-time and shared care bed spaces for both adults and children with a disability.

Overall Findings:
The inspection was unannounced and focused on actions taken by the provider and person in charge to address the findings of the previous inspection, which occurred on the 7 March 2017. The inspector did not look at all aspects of the service provided at the centre, with five outcomes inspected as part of the follow-up inspection.

The inspector found that the provider and person in charge since the previous inspection had further developed the centre's governance and management systems which had ensured that a large proportion of the previous inspection's findings were addressed. However, the inspector found that some actions relating to staff training, adequate staffing levels and personnel file information had not been addressed within agreed timeframes.

The inspector found that management systems at the centre ensured that a safe service was provided to residents, however the provider had not ensured that the centre's staffing arrangements consistently addressed residents' healthcare needs and opportunities for social activities. The provider had commenced following the previous inspection an annual schedule of audits, regular team meetings and formal staff supervision arrangements which ensured that the centre was effectively monitored.

Furthermore, the provider had ensured that improvements required to fire safety arrangements at the centre such as fire door self closures and fire exit signage had been address following the previous inspection. However, during the course of the inspection, the inspector observed fire safety risks in relation to the effectiveness of the centre's fire doors to contain the spread of fire, and as a result an immediate action was issued to the provider under regulation 28(3) (a) of the Health Act 2007 (Care and support of residents in designated centres for persons (children and adults) with disabilities) regulation 2013.

Summary of regulatory compliance:
The centre was inspected against five outcomes. The inspector found major non-compliance in three outcomes relating to fire safety, adequate staffing arrangements

and staff training and documentation. Moderate non-compliance was found in two outcomes in relation to annual resident personal plan reviews and governance arrangements at the centre.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The inspector found that overall residents' personal plans were up-to-date and reviewed, although one resident had not had an annual personal plan review at the centre.

The inspector did not look at all aspects of this outcome and centred on actions taken by the person in charge to address the findings of the centre's previous inspection.

Action 1
The previous inspection had found that annual reviews did not consistently assess the effectiveness of the plan to met residents' needs and goals. The provider had assured HIQA that by the 30 April 2017 the effectiveness of each plan would be reviewed and updated.

The inspector reviewed a sample of residents' personal plans and found that they had been updated by resident's named nurse and associated professionals such as clinical psychologist. In addition, personal plans sampled by the inspector were comprehensive in nature and reflected residents' supports needs and staff knowledge in areas such as communication, healthcare and behaviours of concern. In addition, the inspector found that all aspects of the effectiveness of the residents' personal plan were updated and reviewed and this was reflected in review meeting minutes examined.

Action 2
The previous inspection found that residents' personal plans (including accessible versions) had not been updated following review meetings. The provider assured HIQA that by the 30 April 2017, residents' personal plans would be updated.

The inspector reviewed resident's personal plans which had been subject to an annual review and found that they had been updated in-line with recommendations reflected in review meeting minutes sampled.

Action 3
The previous inspection had found that not all residents had an accessible version of their personal plan. The provider assured HIQA at by the 30 April 2017 all residents would have an accessible version of their personal plan.

The inspector found that the person in charge had ensured that all residents had an accessible version of their personal plan available to them. Accessible plans reviewed used a combination of words, photographs and symbols which reflected residents' communication need. The accessible plans also included information on residents' goals which reflected both the person's developmental needs and interests.

Action 4
The previous inspection found that not all residents' personal plans had been subject to an annual review. The provider assured HIQA that by the 30 April 2017, all personal plans would have had an annual review.

The inspector found that annual review meetings had occurred for the majority of residents whose personal plans had not been reviewed for over 12 months. However, the person in charge had been unable to facilitate one resident's personal plan review due to the availability of multi-disciplinary professionals, although a date had been scheduled for June 2017.

Action 5
The previous inspection had found that residents' assessed behavioural needs were not met by supports at the centre. The provider had assured HIQA that y the 31 March 2017 all behaviour support plans would be reviewed by a clinical psychologist.

The inspector found that all behaviour support plans in place at the centre had been reviewed and approved by a clinical psychologist following the previous inspection. Furthermore, the inspector found that staff knowledge reflected residents' behaviour plans and recommended strategies such as one-to-one support were in place.

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

Findings:
The inspector found that fire safety arrangements at the centre did not ensure the containment of fires. However actions from the previous inspection had been addressed by the provider and person in charge.

The inspector did not look at all aspects of this outcome and focused on actions taken by the provider to address the findings of the previous inspection

Action 6
The previous inspection had found that risk management arrangements at the centre;
- Had not identified and assessed all observed risks
- Risk assessments had not been reviewed in-line with agreed timeframes
- Risk assessment recommendations had not been reviewed in-line with agreed timeframes
- Risk management audits had not been conducted in-line with the provider's policy

The provider had assured HIQA, that by the 31 March 2017 that the following would be in place.
- The person in charge would commence quarterly audits f risks on the centre's risk register
- The person in charge would commence a health and safety audit
- Residents behaviour support plans would be updated in liaison with a clinical psychologist
- The person in charge would ensure that staff were updated on residents' behaviour support plans
- The provider's risk management policy would be available at the centre

The inspector found that the centre's risk register and risk assessments had been reviewed and updated following and reflected risks observed and staff knowledge.

The provider had introduced an annual schedule of audits which related to health and safety and risk management. The inspector found that audits had commenced in-line with the provider's schedule and had been carried out on areas such as health and safety, infection control, use of restrictive practices, fire safety and incidents and accidents. Furthermore, where actions had been identified through the audits, agreed actions and timeframes were recorded in documents reviewed.

The inspectors reviewed residents' behaviour support plans and found that they had been updated and approved by a clinical psychologist and were reflective of observed practices and staff knowledge.

The inspector found that the provider's risk management policy was available at the centre on the day of inspection.

Action 7
The previous inspection had found that access to a fire exit at the centre was obstructed

due to;
- Fire exit signage was not displayed
- The fire exit door's key was not available in adjacent break glass unit
- The fire escape route was not free of obstructions

The provider assured HIQA that by 7 March 2017 they would ensure the fire exit was indicated by a temporary sign and remain unlocked, and the escape route was kept free of obstructions. Furthermore, the provider told HIQA that by the 31 May 2017 they would approve works to install additional signage and access to the fire exit.

The inspector found that the provider had ensured that an illuminated fire exit sign was installed and that the fire exit door was open or if locked a key was located in an adjacent break glass unit. Furthermore, the inspector observed that the escape route was free from obstruction on the day of inspection.

Action 8
The previous inspection had found that fire doors were wedged open at the centre. The provider had assured HIQA that by the 31 May 2017 works would be approved and commenced to address this finding.

The inspector found that works had been completed at the centre, and all fire doors had been installed with a self closure device.
However, during the inspection, the inspector found that the following risks had not been addressed under the centre's fire safety arrangements.

- Hallway fire doors did not fully close
- Residents bedroom fire doors were found to have missing intumescent fire seal strips
- Resident bedroom and communal fire doors had an excessive threshold gap

Due to the identified risks, the provider was issued with an immediate action under regulation 28(3) (c) which related to the provision of adequate arrangements for the containment of fires.

Action 9
The previous inspection had found that not all staff had received fire safety training at the centre. The provider had assured HIQA that by the 31 may 2017 all staff would have received up-to-date training.

The inspector reviewed training records and found that all staff engaged at the centre had received up-to-date fire training. Furthermore, the inspector spoke to staff and found their knowledge reflected the centre's fire evacuation plan.

Action 10
The previous inspection had found that only one simulated fire drill had occurred under minimal staffing conditions at the centre in 2016. The provider had assured HIQA that by the 31 March 2017 they would ensure that simulated fire drills occurred quarterly and under minimal staffing conditions.

The inspector found that since the previous inspection three simulated drills had been

carried out at a range of times and under minimal staffing conditions. In addition, an annual schedule was in place for further drills at the centre. The inspector further found that where issues had occurred during simulated drills in relation to the safe evacuation of residents, support arrangements had been updated in residents' 'Personal Emergency Evacuation Plan's and reflected staff knowledge

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
The inspector found that the provider and person in charge had addressed all actions from the previous inspection apart from the provision of positive behaviour management training; however a schedule was in place to ensure this action was addressed as agreed in the response to the centre's previous inspection.

The inspector did not look at all aspects of the outcome and focused on the by the person in charge and provider to address the findings of the previous inspection at the centre.

Action 11
The previous inspection had found that resident's behaviour support plans had not been regularly reviewed and developed with a behavioural specialist. The provider had assured HIQA that by the 31 March 2017, residents behaviour support plans would be reviewed and approved by a clinical psychologist

The inspector reviewed a sample of residents' behaviour support plans and found that they had been reviewed and updated in conjunction with the provider's clinical psychologist and reflected staff knowledge.

Action 12
The previous inspection had found that not all staff at the centre had received positive

behaviour management training. The provider had assured HIQA that staff would receive training and a schedule would be in place to ensure this occurred by the 31 December 2017.

The inspector found that staff had not received positive behaviour training; however, one staff member had been trained as an accredited trainer in the provider's preferred positive behaviour management course. Furthermore, the inspector was shown a training schedule which would ensure that all staff at the centre would have completed training by the 7 December 2017.

Action 13
The previous inspection had found that not all staff were aware of the centre's 'Designated Liaison Person for Children', and had not received Children's First training. The provider had assured HIQA that by the 30 March 2017, the role of the designated liaison person would be discussed at the next staff team meeting.

Staff told the inspector that they had received information about the designated liaison person for children in the centre's team meeting. In addition, staff told the inspector who the designated children's liaison person was for the centre and that they would contact them if they had any concerns regards children in the centre's care. Information on the centre's designated liaison person for children was prominently displayed at the centre.

The inspector reviewed staff training records and also following the close of the inspection received information that showed that all staff had received up-to-date Children's First training in-line with the provider's policies.

Action 14
The previous inspection had found that not all staff had received safeguarding of vulnerable adults training. The provider had assured HIQA that all staff would receive training by the 10 April 2017.

The inspector found that staff were knowledgeable on what might constitute abuse and the actions they would take if witnessed or suspected, which was in line with the provider's policies. In addition, the inspector reviewed the centre's training records and found that all staff had received up-to-date safeguarding of vulnerable adults training.

Action 15
The previous inspection had found that safeguarding plans in place at the centre were not robust in nature and did not reflect observed practices. The provider assured HIQA that by the 31 March 2017 the person in charge and designated safeguarding officer would review all plans and ensure they included recommended interventions.

The inspector reviewed safeguarding plans in place at the centre and found that they had been reviewed and amended to become more robust in nature. Furthermore, safeguarding plans examined were reflective of observed practices at the centre and in-line with staff knowledge.

Judgment:
Non Compliant - Major

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

Findings:
The inspector found that governance and management arrangements at the centre had improved, although not all actions from the previous inspection had been addressed.

The inspector did not focus on all aspects of this outcome, focusing on actions taken by the provider to address the centre's previous inspection findings.

Action 16
The previous inspection had found that management systems in place at the centre did not promote the delivery of safe, quality care services. The provider had assured HIQA that by the 15 March 2017 a schedule of audits would be developed and commenced by the person in charge.

The inspector found that an annual schedule of audits had commenced and were being carried out at the centre in line with the provider's timeframes and included areas such as health and safety, infection control, residents' personal plans, residents' financial records, fire safety and medication management. In addition, the inspector found that audits included action plans which indicated persons responsible and timeframes, for any deficits in practice to be completed.

However, although governance and management arrangements at the centre had improved, the inspector found that not all actions from the previous inspection such as staff training and residents' annual reviews had been completed within the agreed timeframes.

Action 17
The previous inspection had found that the centre had not completed an annual review into the care and support provided at the centre. The provider assured HIQA that a completed annual review would be in place by the 31 March 2017.

The inspector found that the provider had completed an up-to-date annual review of the care and support provided at the centre. The inspector found that the review included both consultation with residents and their representatives and was available at the centre.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

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

Findings:
The inspector found that although formal staff supervision arrangements had commenced at the centre, the provider and person in charge had not ensured adequate staffing arrangements were in place to meet residents' assessed need. Furthermore staff had not accessed up-to-date training and staff documentation was not in-line with Schedule 2 of the regulations.

The inspector did not look at all aspects which related to this outcome, and focused on actions undertaken by the provider to address the findings of the previous inspection.

Action 18
The previous inspection had found that staffing levels at the centre did not meet residents' assessed needs. The provider had assured HIQA that by the 15 June 2017 they would submit a business case for the recruitment of two staff nurse positions at the centre.

The inspector found that although a business case had been submitted on the positions, the person in charge had not received the outcome of this proposal. The inspector found that the provider continued to not ensure that adequate staffing arrangements were in place to met both residents' healthcare needs and facilitate access to community activities. The inspector was told by staff and the person in charge that due to residents' needs a nurse was required at all times to meet healthcare needs. However, adequate nursing staff levels were not available at all times to allow both residents' activities and healthcare needs to be met, unless residents; requiring nursing support, attended

community activities as a group or activities were cancelled. In addition, the
The inspector further found from a review of the centre's roster that the person in charge had at times been able to facilitate a second nurse on duty or provided this role themselves, but this was not a consistent practice at the centre.

Action 19
The previous inspection had found that staff personnel files did not contain all required information under Schedule 2 of the regulations. The provider had assured HIQA that by the 15 March 2017 all documentation required under Schedule 2 would be in place.

The inspector sampled staff personnel files and found that staff files still did not contain the required information under Schedule 2 of the regulations. The inspector found the following documentation absent from staff files sampled.
- Copies of Birth certificates
- Copies of qualifications
- Copies of employment contracts
- Proof of Garda vetting

Action 20
The previous inspection found that staff were not suitably supervised at the centre. The provider had assured HIQA that from the 15 March 2017, bi-monthly staff governance meeting would commence. In addition, the provider told HIQA that a schedule would be in place by the 31 May for the completion of all staff's 'Personal Development Plans' (PDPs).

The inspector reviewed team meeting minutes and found that a meeting had occurred in March 2017 and was scheduled to occur on the day of inspection which was reflected in discussions with staff. Furthermore, the inspector was shown a schedule of bi-monthly team meetings for the year.

The inspector found that the person in charge had commenced PDPs with staff. Staff told the inspector that they had met with the person in charge or nurse and had discussed their role at the centre and training needs which was reflected in PDPs sampled.

Action 21
The previous inspection had found that not all staff had up-to-date training which reflected residents' needs and the provider's policies. The provider told HIQA that this would be addressed by means of:
- The provider's policies being a standing agenda on staff governance meetings by the 30 March 2017
- The centre's staff training plan would be implemented by the 31 March 2017.

The inspector reviewed staff governance meeting minutes and found that the provider's policies and procedures had been discussed with staff. In addition, the person in charge had a list of standing agenda topics for team meetings which included the provider's policies.

The inspector found that the provider had an annual training plan. In addition, records

showed that staff had received up-to-date training on fire safety and safeguarding of vulnerable adults. However, the provider had not ensured that all staff had received up-to-date training in manual handling, food hygiene and hand hygiene.

Action 22
The previous inspection had found that staff were not aware of the 2007 Health Act and their regulatory requirements. The provider assured HIQA that by the 30 March 2017 they would provide information to staff on the Health Act through the staff governance meeting.

The inspector found the provider's representative had facilitated training on the Health Act 2007 which was reflected in discussions with staff. Furthermore, the inspector observed that information was displayed in the centre's office on the requirements of the Act such as notifiable events and inspection reports and regulatory guidance was available to 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:

Stevan Orme
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002523
Date of Inspection:	30 May 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 inspector found that one resident had not had an annual personal plan review at the centre.

1. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

Please state the actions you have taken or are planning to take:
The outstanding annual review has been arranged for 23rd June 2017.

Proposed Timescale: Completed by 23rd June 2017

Proposed Timescale: 23/06/2017

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 inspector found that the centre's fire doors did not provide adequate arrangements for the containment of fires.

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

Please state the actions you have taken or are planning to take:
1. The company were onsite completing works and they explained to the inspector that the doors closures speed were in line with the regulations set out by the fire officer and the inspector was satisfied with this

2. There were 2 residents bedrooms that had a missing intumescent strip on the lower half of the door, This was put in place before 5pm on the 31st May 2017 (day after inspection) and the inspector was advised of the completion of this action via e mail by the provider nominee

3. There was an excessive threshold gap noted in 1 communal area and 3 residents bedrooms this was rectified by a registered tradesman before 5pm on the 31st May 2017 (day after the inspection) and the inspector was advised of the completion of this action via e mail by the provider nominee

Proposed Timescale: All Completed 31st May 2017

Proposed Timescale: 31/05/2017

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 inspector found that not all staff had received positive behaviour management training.

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

Please state the actions you have taken or are planning to take:
1. All staff will attend MCB (5 modules) training.
2. Four staff are scheduled to attend studio III training on the 21st 22nd and 23rd June.
3. There is a schedule in place to ensure all remaining staff receive Studio III training by December 31st 2017

Proposed Timescale: 1. July 14th 2017, 2. June 23rd 2017, 3. December 31st 2017

Proposed Timescale: 31/12/2017

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 all actions from the previous inspection were addressed within agreed timeframes with the Health Information and Quality Authority.

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

Please state the actions you have taken or are planning to take:
1. Residents review is arranged for 23rd June 2017
2. All staff scheduled to attend MCB (5 modules) by July 14th 2017. concern

Proposed Timescale: 1. 23rd June 2017, 2. 14th July 2017

Proposed Timescale: 14/07/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels at the centre did not met residents' needs

5. 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:
Business cases have been submitted to fill the 2.0 WTE staff Nurses posts which are vacant.

Proposed Timescale: 31/07/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff files did not contain all information required under Schedule 2 of the regulations

6. 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:
1. Staff have been asked to submit birth certificates (9 already on file)
2. Registered nurses have been asked to submit a copy of their original qualification (4 on file)
3. There were 2 outstanding contracts of employment 1 has been sourced and we are awaiting the 2nd one from personnel
4. The garda vetting for the PIC and PPIM will be available on site with full disclosure and all staff will have garda vetting as per national standard operating procedure for garda vetting which came into effect on 6th June 2017

Proposed Timescale: 1. 23rd June 2017, 2. 23rd June 2017, 3. 30th June 2017, 4. 30th June 2017

Proposed Timescale: 30/06/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have up-to-date training in line with the provider's policies.

7. Action Required:

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

Please state the actions you have taken or are planning to take:
1. All staff have completed manual handling training other than staff on sick leave
2. 1 staff member has been scheduled to attend the next date for food hygiene
3. All staff will complete hand hygiene training, all staff have completed the online e learning and the practical will be done on site

Proposed Timescale: 1. 12th June 2017, 2. 30th August 2017, 3. 14th July 2017

Proposed Timescale: 30/08/2017