<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>A designated centre for people with disabilities operated by Sunbeam House Services Ltd</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>ORG-0007948</td>
</tr>
<tr>
<td><strong>Centre county:</strong></td>
<td>Wicklow</td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Sunbeam House Services Ltd</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>John Hannigan</td>
</tr>
<tr>
<td><strong>Person in charge:</strong></td>
<td>Michele Geoghegan</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Michael Keating</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>0</td>
</tr>
</tbody>
</table>
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.
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 announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 13 February 2014 10:30
To: 13 February 2014 18:00

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12. Medication Management</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This monitoring inspection of was the first inspection of this residential centre by the Health Information and Quality Authority. As part of the inspection, inspectors met with residents and staff members. The designated centre is part of Sunbeam House Services Limited, and as part of this inspection process, two inspectors met the nominated person on behalf of the provider as well as other members of the management team at the Sunbeam House Services Head Offices.

Sunbeam House Services is governed by a board of directors consisting of 9 members, with John Hannigan as CEO. Mr Hannigan is also the person nominated on behalf of the provider and will be referred to as provider throughout the report. Mr Hannigan is supported in his role by the senior management team which is made up of seven managers with a variety of roles and responsibilities. During discussions, the provider and senior management team demonstrated a commitment to providing a good quality service with clear reporting systems in place. However, some improvements were required to ensure that corporate policies were implemented at local level, for example local risk registers and follow through on health and safety audits.

Generally, the inspector found that residents received a good quality of service in the centre. Staff supported residents in making decisions and choices about their lives. The centre had a warm atmosphere and inspectors found that residents were comfortable and confident in telling the inspector about their home. Residential services while campus based, are provided across two separate houses, and the
bigger of these houses is subsequently divided into two separate parts. Three defined residential units are therefore separately distinguished as the Elms, Pines and the Oaks.

While there was evidence of good practice found across all outcomes, areas of non compliance with the regulations were identified across the seven outcomes inspected against. Improvements were required across all outcomes.

These non compliances are discussed in the body of the report and included in the action plan at the end of this report.

<table>
<thead>
<tr>
<th>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 and the National Standards for Residential Services for Children and Adults with Disabilities.</th>
</tr>
</thead>
</table>

**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

**Judgement:**
Non Compliant - Minor

**Findings:**
In general, the inspector found that residents were involved in the development of their personal plans and that staff provided a good quality of social supports to residents. Each resident had a personal plan and inspectors viewed five of the plans, and discussed some of these plans with respective key workers. They were based on the individual support needs of the resident. However, all plans and related goals were out of date, and required review.

The personal plans contained important information about the residents' backgrounds, including details of family members and other people who are important in their lives. They also contained information about residents' interests. Plans were being used to identify the wishes of residents' daily activities, particularly for those who had chosen not to participate in formal day services as provided within the broader organisation. For example, one man attends a local joinery shop, where he enjoys demonstrating his carpentry skills, and he discussed this with the inspector on his return. Staff were available during the day to provide residents the opportunity to stay at home and pursue other interests, or to access the community.
While the personal plans included planned activities such as visits home or attending sporting occasions, they were not focused on longer term developmental outcomes for residents, and it was not possible to use the plans to evaluate whether the activities enhanced the quality of life for residents. Additionally, daily reporting notes were not feeding into plans and were not being assessed or audited in order to monitor if goals were being achieved.

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

_The health and safety of residents, visitors and staff is promoted and protected._

**Theme:**
Effective Services

**Judgement:**
Non Compliant - Major

**Findings:**
The inspectors were satisfied that there was evidence of a commitment to risk management and health and safety within Sunbeam House Services. The provider had introduced a new corporate risk register, however, this had yet to be fully implemented locally. Inspectors read a comprehensive risk management policy which had recently been drafted and found that it clearly identified the roles, responsibilities and reporting arrangements for managing risk, however the policy required further improvements. For example, the risk management policy did not include the specific risks outlined within the regulation, for example the risk of self harm.

The inspector read the Health and Safety Statement, as well as the Health and Safety Audit which was completed by an external company in July 2013. Clear recommendations were identified in this audit. However, the person in charge was unclear as to whether these recommendations had been addressed to date. The risk management policy was in draft format and was reviewed by inspectors in head office and contained most of the information as required in the Regulations.

Generally, the inspector found that the provider had not put sufficient risk management procedures in place. A number of residents' specific behaviours had been highlighted to the inspector throughout the inspection. Staff informed the inspector about many of these behaviours and related incident reports were read by inspectors. Additionally care plans and individual risk assessments did not provide clear guidance to staff in relation to the management of these behaviours, and staff communicated many variances in relation to how some of these behaviours were managed. While the person in charge reported that individual assessments carried out by social workers and psychiatrists are in the residents main files within the organisations head office, these reports were not seen by the inspector, and were not sufficiently guiding practice within the centre.

There were regular fire drills and both staff and residents participated. Residents and staff were able to tell the inspector what they would do if the fire alarm went off. The
records of the fire drills, included vehicle evacuation drills, and were detailed and included learning outcomes. The inspector viewed evidence that fire equipment was serviced regularly, as were fire alarms and emergency lighting. Fire evacuation plans were posted clearly in a number of places throughout the centre. Records reviewed by inspectors indicated that all staff had participated in fire training within the past three years.

**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.*

<table>
<thead>
<tr>
<th>Theme: Safe Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judgement: Non Compliant - Moderate</td>
</tr>
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</table>

**Findings:**
Overall, the inspector found that staff were promoting the safety of residents, however improvements were required.

Staff told the inspector that they were aware of the importance of promoting the safety and respect for each resident. The inspector observed staff interacting with residents in a respectful and friendly manner. Staff had developed an intimate care plan for any residents whose personal care was provided or supported by staff. These intimate care plans ensured privacy, provided protection to residents from any risk during the delivery of intimate care and respected and promoted the minimal support required from staff.

However, some improvements were required in the policy and the provision of training. While staff were knowledgeable about what constituted abuse, and how they would respond to any suspicions of abuse, not all staff had been provided with training on the protection of vulnerable adults. However, the training plan provided, confirmed that all staff are due to participate in revised protection and safeguarding training in the coming months. The person in charge has also been trained to provide this training.

The inspector was concerned that one resident experience in the centre was having a negative impact on their lived experience. This resident informed the inspector that he felt 'bullied' by other residents and was 'worried' some times. When inspectors asked staff about this account, they agreed that this was a likely living experience for this man, however there was a lack of evidence of what measures had been put in place to minimise this experience.

The inspector found that a number of residents required behavioural support
interventions due to behaviours they displayed. However, there were no clear comprehensive support plans in place for these individuals in order to guide staff and to provide effective assessment and review for the staff and residents concerned. For example, there were no clear plans in place around the management of specific sexualised behaviours or clear plans to follow where residents leave or fail to return to the centre as planned.

The inspector noted that restraint has been used in the centre recently, but on review of this residents care plan there was no clear guidance in relation to behaviour that necessitated this intervention.

The inspector was very concerned regarding the use of Closed Circuit Television (CCTV) throughout the centre; there were ten cameras in use throughout the 'Pines' and 'Elms' while eight more were operating in the 'Oaks'. Furthermore, there were six monitoring points throughout the centre, and some of these were in public areas such as the sitting or dining rooms. While none of the cameras were operating in private areas such as bathrooms or bedrooms, they were covering communal areas such as sitting rooms and the games room as well as corridors. These cameras were impinging upon the privacy and dignity of all residents. It remained unclear to the inspector if the cameras were being used in a supervisory capacity. The use of CCTV had not been risk assessed, and the reasons for its use was not assessed or documented generally, or in any individual care plans. There was no sufficient policy in place for the use of CCTV, while a draft version of the policy was read, it had insufficient detail, and was not specific to the centre. Inspectors looking at organisational policies within head office, reviewed another version of a CCTV policy which was more detailed. The person in charge was not aware of the existence of this policy.

There was limited evidence in relation to the effective auditing and monitoring of PRN medication (medication that is administered as required). For example, psychotropic PRN medication seemed to be prescribed indefinitely for some residents, with no clear review in relation to the frequency of this intervention, the effectiveness of the intervention, or of a review in relation to any possible reduction in medication. The inspector was informed a review of this system in currently being undertaken, as part of the broader move to more computer based record keeping.

<table>
<thead>
<tr>
<th>Outcome 11. Healthcare Needs</th>
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</thead>
<tbody>
<tr>
<td><strong>Residents are supported on an individual basis to achieve and enjoy the best possible health.</strong></td>
</tr>
</tbody>
</table>

**Theme:**
Health and Development

**Judgement:**
Non Compliant - Moderate

**Findings:**
The inspector found that in general residents were supported to access health care
services relevant to their needs. The inspector reviewed medical notes of five residents, and found that they had access to a general practitioner, as well as allied health care professionals such as psychologists and psychiatrists.

Overall the inspector found that where required, residents had care plans commenced for health related issues such as hypertension or chronic obstructive airways disease. These plans were up to date and relevant to the assessed needs of the resident. However, the inspector noted that one resident required review for ongoing progressive health related issues and an up to date care plan that guided staff in a holistic approach to his care. This was discussed with the person in charge during the inspection.

Residents decided on a daily basis what they would like to eat, and it was reported that many residents assist staff in preparing evening meals. Residents could choose an alternative meal if they did not like the meal planned. All staff were responsible for food preparation and have completed food hygiene training. There have not been any Environmental Health Office (EHO) inspections in recent years. However, inspectors observed there was adequate and appropriate provision for storage of food, and overall there was a high standard of hygiene maintained throughout the centre.

### Outcome 12. Medication Management

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

**Theme:**

Health and Development

**Judgement:**

Non Compliant - Moderate

**Findings:**

Generally, the inspector found that the provider had put arrangements in place to support the person in charge in protecting residents in relation to medication management. All staff employed in the centre are nursing qualified. A comprehensive medication management and training policy was viewed by inspectors in head office.

Medications are dispensed from the pharmacy in blister packs to promote the correct administration. A clear description of each medication is provided on the blister pack to ensure that staff could recognise the correct medication to be administered. The receipt of medication was being recorded and medication was stored in locked cabinets within the staff office(s). The general practitioner had signed the prescribing sheet for each medication, and the prescription included clear directions to staff on the dose, route and times that medication should be administered. PRN medications (medications that are administered as required) were recorded on the prescription sheet and these included the maximum dose that should be administered in any 24 hours.

However, breaches in policy were identified on the day of inspection, where the administration sheet had not been signed for two residents who were prescribed
medication for the morning of the inspection. This was discussed with the person in charge during the inspection.

**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

**Judgement:**
Non Compliant - Moderate

**Findings:**
The designated centre is part of a larger organisation with a clearly defined management structure which identifies the lines of authority and accountability in the centre. However, a number of staff members raised similar concerns with the inspector relating to aspects of management which they felt was impacting upon their ability to provide safe services for all residents. Specific concerns relate to:

- residents who may leave, or not return to the centre as planned; staff reported receiving mixed message from senior management and residents psychiatrist in relation to how the clear actions to follow in the event a resident chooses to leave the centre.

- lack of suitable training around the management of sexualised behaviours.

- lack of guidance on how to support new staff of visitors, around residents who may present with sexually inappropriate behaviour.

- concern around the welfare and protection of vulnerable residents.

The person in charge was deemed to be suitably qualified and experienced and provides solid leadership to her staff team. She demonstrated good knowledge of all of the residents, and the residents could clearly identify with her, and were very relaxed in her company. The staff roster clearly identifies who is in charge on any given shift. In this regard the person in charges' actual hours worked should be identifiable on the final roster, in order to clearly demonstrate how actively involved the person in charge is in the governance, operational management and administration of this centre on a regular and consistent basis.
<table>
<thead>
<tr>
<th>Outcome 17: Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

| Theme: |
| Responsive Workforce |

| Judgement: |
| Non Compliant - Moderate |

| Findings: |
| The provider had ensured that there were robust recruitment processes in place and that staff employed in the centre were suitable to work with vulnerable adults. Actual rosters should identify all staff who has worked on any given shift including agency staff. |

| Inspectors reviewed the records relating to staffing and found that they contained most of the information outlined in Schedule 2 of the regulations; however some improvements were required to be fully compliant. For example photographic proof of Identify had been sought for all new staff since the introduction of the regulations; however this had not been done retrospectively for staff employed before 1 November 2013. |

| Training records were available though the organisations intranet system and inspectors reviewed these records in detail. The inspectors were also provided with a printed copy of the training records for all staff members. The inspectors identified areas of training which were required for some staff members such as adult protection (safeguarding) training. Staff interviewed confirmed that they were awaiting training in these areas. The person in charge showed the inspector a plan to provide training to all staff in revised protection and safeguarding training in the coming months. |

| There were regular supervision arrangements in place such as staff meetings which were held every six weeks, and a more formal system of one to one supervision between the person in charge and staff members has recently been initiated. Many staff have been working in the centre for a long period of time, and had an in depth knowledge of the residents, staff were observed supporting and engaging with residents in a person centred, professional and friendly manner. Staff also discussed residents in a very respectful and positive way, and were very knowledgeable in relation to individual needs of the residents. |
**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

**Report Compiled by:**

Michael Keating  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
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<tr>
<td>Date of Inspection:</td>
<td>13 February 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19 May 2014</td>
</tr>
</tbody>
</table>

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

All personal plans reviewed were in need of review.

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.

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

All Personal plans will be reviewed. 31st May 2014 and monthly by keyworkers.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Proposed Timescale: 31/05/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents’ personal plans tended to be activity rather than outcome based and it was not possible to assess or demonstrate the effectiveness of each plan.

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:
Regular key-working meetings with clients will be implemented. Key-working document drawn up and reviewed by CSM ever month to monitor effectiveness of outcomes identified and whether goals are being achieved.

Proposed Timescale: 30/06/2014

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:
There was no system in place to ensure recommendations of health and safety risk audits had been implemented.

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:
An audit template has been developed and will be distributed to all locations.

Proposed Timescale: 30/04/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy and register did not assess all of the risks in the centre.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.
Please state the actions you have taken or are planning to take:
The safety statement and draft risk Management policy and framework reference
Hazard identification and assessment of risk.
A location specific risk register will be developed by July 1st 2014

**Proposed Timescale:** 01/07/2014

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The measures and actions in place to control aggression and violence were not clearly identified.

**Action Required:**
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
CSM will discuss with all staff individually that they are confident and competent to use SHS policy on CPI’s accredited training in Non Violent Crisis Invention. This is SHS’s current policy in relation to managing aggression and violence. Each meeting will be recorded and signed by CSM and staff member and this review will be completed by August 31st 2014.
All staff are being booked for refresher training. Refresher training in Non Violent Crisis Intervention will be completed by October 17th 2014. All Positive Intervention Plans are being reviewed. Positive intervention Plans will be reviewed by August 31st 2014

**Proposed Timescale:** 17/10/2014

**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:
There was no evidence that where a resident's behaviour necessitates intervention under this regulation that:
- all alternative measures are considered before a restrictive procedure is used; and
- the least restrictive procedure, for the shortest duration necessary is used.

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

Please state the actions you have taken or are planning to take:
Review of current restrictive practices in relation to the use of Non violent Crisis Intervention will be submitted to the Rights Review Committee.

**Proposed Timescale:** 30/06/2014  
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was no risk assessment or appropriate policy in place for the use of CCTV throughout the centre. The reason for the use of CCTV was not assessed and recorded for any residents.

**Action Required:**  
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**  
This policy will be amended and be in place by May 31st.

**Proposed Timescale:** 31/05/2014  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Effective review of the use of medication to manage behaviour that challenges was insufficiently monitored and reviewed.

**Action Required:**  
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**  
All client’s medication including psychotropic PRN medication will be reviewed by psychiatrist. All clients will be reviewed by Psychiatrist by August 31st  2014

Regular PRN medication will be reviewed as part of Monthly Medication Audit. Monthly Medication Audit will be in place from 30th June 2014

**Proposed Timescale:** 31/08/2014  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Appropriate training to be provided to staff in relation to safeguarding of residents and
the prevention, detection and response to abuse.

**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:**
All staff are currently booked in for Safeguarding Training. Training for staff member interviewed on inspection day will be completed on 18th June 2014. All staff will have completed this training by 25th September 2014.

**Proposed Timescale:** 25/09/2014

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### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Ensure all residents receive a timely review of their health care plan according to individual need.

**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:**
Five clients files were reviewed and one needed further development this client is in the assessment stage of a recently diagnosed health issue. Care plans reviewed 24/04/2014 and 28/04/2014

**Proposed Timescale:** 28/04/2014

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### Outcome 12. Medication Management

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Administration of medication sheets were not signed for all residents on the morning of inspection.

**Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.
Please state the actions you have taken or are planning to take:
Monthly medication audit will be implemented and carried out by identified staff member. This will be reviewed by CSM. Staff who take medication with clients when out and about will note this in comments section of signing sheet and identify medication removed from location using letters assigned to each prescribed medication. Staff will sign administration record on return to residence.

Proposed Timescale: 30/06/2014

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:
Arrangements were not in place to ensure staff exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
Some staff at this location have done training in working with people who sexual offend. Further training in the management of sexualised behaviours will be planned for this staff team.

Proposed Timescale: 31/08/2014

Outcome 17: Workforce
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The actual staff roster should identify all staff (including the person in charge) who were working in the premises at any given time.

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

Please state the actions you have taken or are planning to take:
The person in charge will be identified on the staff roster.
<table>
<thead>
<tr>
<th>Proposed Timescale: 30/04/2014</th>
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<tbody>
<tr>
<td>Theme: Responsive Workforce</td>
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</table>

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all information required in Schedule 2 had been obtained for staff employed prior to 1 November 2013.

**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:**
This is a challenge for all locations and is currently being pro-actively addressed.

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<thead>
<tr>
<th>Proposed Timescale: 01/09/2014</th>
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<tbody>
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<td>Theme: Responsive Workforce</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff have not received mandatory training.

**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:**
All staff will complete this training.

| Proposed Timescale: 25/09/2014 |