<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011637</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Dublin 15</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:sandra.nelson@docservice.ie">sandra.nelson@docservice.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Daughters of Charity Disability Support Services Ltd.</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Mary O'Toole</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Sandra Nelson</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Nuala Rafferty</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Florence Farrelly</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>12</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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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 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 compliance with National Standards. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 10 March 2014 10:30   To: 10 March 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 06: Safe and suitable premises</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 11: Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12: Medication Management</td>
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<tr>
<td>Outcome 13: Statement of Purpose</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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<tr>
<td>Outcome 17: Workforce</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This was the first inspection of this dementia specific centre by the Health Information and Quality Authority (the Authority). The purpose of the inspection was to assess the level of compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013 and the standard of care delivered to residents in the facility.

This centre forms part of a number of diverse service to persons with disabilities delivered by the provider Daughters of Charity on the St Joseph's campus in Clonsilla Dublin and are considered to meet the criteria for registration as a designated service under the Health Act 2007.

The inspection was announced and took place over one day. As part of the inspection process inspectors met with the provider nominee, person in charge, management team, staff, volunteers and residents. Inspectors observed practices and reviewed documentation such as clinical care records, policies and procedures and staff files.

The centre is situated in a purpose built setting specifically designed to support and meet the needs of persons with disabilities and mid or late stage dementia. The centre is finished to a very high standard with all of the appropriate assistive equipment required to meet residents needs contained within a domesticated setting.
with stylish but comfortable furnishings, décor, fixtures and fittings.

Throughout the inspection it was noted that a real emphasis was placed on delivering safe suitable and appropriate care within an atmosphere of domesticity, normalisation and socialisation. Each resident was facilitated to exercise choice and control over all aspects of their day in a tangible, meaningful way. Staff were found to deliver effective care in a low key, unobtrusive and respectful manner.

The findings are detailed under each outcome in this report, in general evidence of good standards of practice were found although improvements were noted to be required in some aspects of service delivery including; risk management, medication management and meeting social care needs. Where non compliances are identified an action plan is included under each outcome and identifies areas where improvements are required to comply with the regulations and Authority's standards.
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.

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 - Moderate

Findings:
Throughout the visit it was noted that an emphasis was placed on ensuring residents were offered opportunities to participate in meaningful activities, appropriate to his or her interests and preferences throughout the day. Staff and volunteers created an atmosphere of domestic home life where each person was involved. Residents were facilitated to independently bake fairy cakes and muffins, set the dining table for lunch, and go out for walks in the garden, with assistance where required. Appropriate music played quietly in the background and residents moved freely about the house looking at photographs of outings, having their nails painted, receiving hand massage or sitting enjoying each other's company. The promotion of independence through skill maintenance and retention was also emphasised. This was demonstrated on an ongoing basis throughout the day with residents' encouraged to be self caring where possible, for example, each resident was encouraged to eat independently, to select and bring their chosen drink to the table at lunch, to decide where and with whom they sat or in which activity they wished to engage. Cognitive stimulation through questions, choices and reminiscence was a consistent theme of all interactions by staff. Conversations and explanations were constantly provided so that residents could understand and make informed decisions for themselves.

Evidence that resident’s wellbeing and welfare were maintained by a good standard of evidence-based care and support was found. On review of a small sample of clinical documentation, it was found that arrangements to meet each resident’s assessed needs were set out in a personal plan that reflected needs, interests and capacities. The plans were drawn up with the participation of the resident, relatives, advocates and friends. Maintenance of close links with community groups and former friends were noted to be encouraged and facilitated. Opportunities for health, education training and self fulfilment through sport achievements were found to be included in the personal plans with some residents engaging in external sports training and day care work placements.
The arrangements to meet residents’ assessed needs were set out in individual care plans and each resident had a care plan completed. Risk assessment tools to evaluate levels of risk for deterioration were also completed. Although in general care plans reflected the care delivered, further improvements were found to be required. Risk assessments and care plans were not always linked or revised in all instances to determine their effectiveness and care plans were not always reviewed in response to changes in residents’ health.

**Outcome 06: Safe and suitable premises**
*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Services

**Judgement:**
Compliant

**Findings:**
Although all aspects relating to safe and suitable premises were not reviewed on this visit, it was found that the design, layout, provision of equipment, health and safety aspects, security, decorative features and attention to detail of the premises were found to be of a high standard and suitable for the proposed resident profile for persons with dementia. Appropriate equipment for use by residents or staff was available and maintained in good working order.

The centre consists of two separate units providing models of service to two distinct care groups. One of the units is an eight bedded bungalow for persons who have an intellectual disability and also with mid stage dementia. The second unit is a six bed bungalow for persons who have an intellectual disability and at end stage dementia with high nursing and end of life care needs. The centre was planned and built specifically to support persons with an intellectual disability and dementia. During the planning stage, the principles of current best practice on good environmental design to aid the safe delivery of person centred dementia care were considered.

Both bungalows are co-joined via a central doorway between the kitchen areas and a central shared service area. Although they are distinct and separate services some elements of the building are shared and these include; laundry, cleaning room, large larder store, cold store and catering wash up area. Both units are accessible to persons with limited mobility or are wheelchair users. They each contain spacious single bedrooms with en-suite facilities.
Corridors are sufficiently wide to allow access to power wheelchair users and contain side rails, they also provide small seating areas at regular spaced intervals along the length of the corridor for residents use.

An open plan kitchen dining and living room area provides the focal point for people to gather, engage in domestic activity and chat throughout the day A separate sitting room and conservatory is also available to enjoy for quiet relaxation either alone or with company. Externally, residents in each unit can access enclosed courtyard areas with seating, landscaped shrubberies and raised plant beds.

All furniture fixtures and fittings within the bungalow are visually inviting, stylish, comfortable and serviceable. Together with low key décor, use of colour cueing, bright airy rooms with lots of natural light and large glazed areas, the overall environment presents a warm welcoming safe environment where each individual can live a life of ordinary yet fulfilling life experiences.

**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:**
Although all aspects of the lines of enquiry for this outcome were not reviewed on this visit it was found that in general the health and safety of residents, visitors and staff was promoted and protected in that policies and procedures for risk management and health and safety were available and staff were aware of them.

Arrangements were in place for the maintenance of the fire alarm system and equipment within this centre. Smoke detectors were located in all bedroom and general purpose areas. Emergency lighting and fire exit signage was provided throughout the building. The inspector reviewed service records which showed that fire equipment, the fire alarm system and emergency lighting were regularly serviced. Fire escape routes were unobstructed. Fire procedures and building layout plans showing evacuation routes were displayed in the centre. Records were maintained regarding the servicing of fire equipment and fire officer’s visits. Check lists were also maintained to ensure fire exits remained clear and fire equipment and alarms were tested.

However, all precautions in place against the risk of fire were not found to be adequate to assure the safety of residents’ staff or visitors in the event of a fire or other similar emergency. Although those staff spoken with demonstrated knowledge of the procedures to be followed in the event of a fire, it was found that a simulated fire drill to assess competency and confidence in relation to fire evacuation procedures had not taken place since the centre opened in May 2013 and annual training for staff in fire
safety and evacuation was not provided in 2013 or to date in 2014.

In conversation with the person in charge the inspector learned that discussions with the fire safety officer and senior management team were ongoing in relation to the level of appropriate involvement of the residents in the emergency evacuation process. The person in charge was advocating on behalf of the residents and had concerns that some of the residents did not need to be actively involved in 'live' simulated fire drill exercises. Specifically she referred to those residents with end stage dementia and in receipt of end of life care. Equally the person in charge was very conscious of the need to manage any simulated fire drills with the appropriate safe involvement of other mobile residents without causing distress or upset.

The home was well maintained, visually clean and clutter free, good housekeeping processes ensured residents safety with all chemicals and cleaning agents were stored safely.

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

Judgement:
Compliant

Findings:
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to manage incidents of elder abuse. In conversation with some staff members, the inspector found they were competent in their knowledge regarding reporting mechanisms within the centre and what to do in the event of a disclosure about actual, alleged or suspected abuse. Although all residents spoken too were unable to express feeling safe, the inspector observed they appeared comfortable with staff and did not exhibit behaviours associated with distress or anxiety.

Overall a restraint-free environment was found to be promoted within the centre, behavioural supports to manage behaviour that challenges was not observed during this visit. Restrictive measures such as use of bed rails and lap belts were noted to be in use for some residents, specifically those persons with balance or sitting difficulties who were full time wheelchair users or remained in bed for long periods of time. In conversation with nursing staff and the person in charge it was found that alternative, less restrictive measures were considered or trialled prior to the use of these methods,
however, documentation referencing the need for restraint did not always identify whether the restraint used was suitable for the residents needs without restricting the resident unnecessarily. Improvements to clinical documentation were noted to be required and this is discussed further under Outcome 11.

**Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

**Judgement:**
Non Compliant - Moderate

**Findings:**
Residents had good access to general practitioner (GP) services. A GP and clinical nurse specialist in wound care and dementia visited the centre during the inspection to review residents. There was evidence of access to specialist and allied health care services to meet the diverse care needs of residents such as opticians, dentists and chiropody services. There was also evidence of residents having access to palliative care specialists, speech and language, physiotherapy and dietician services.

Residents were provided with food and drink at times and in quantities adequate for their needs. All main meals were prepared from the main catering kitchen located in a separate building on the campus and brought to the centre in sealed containers. Food was properly served and was hot and well presented. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. Lunch was found to be a relaxed and sociable affair. Residents were facilitated to enjoy their meal independently, privately and at their own pace, where assistance was required it was offered in a discreet and sensitive manner. Serviettes and condiments were on the table.

Menus showed a variety of choices for starters main courses and dessert choices on offer. Drinks such as juices, milk, tea and coffee were freely available and there were ample stocks of fresh food and larder stores to facilitate snacks or meal alternatives as required.

Some residents with end stage dementia had end of life or comfort care plans in place. However, on review it was noted that although staff were conscious of and striving to provide end of life care in a manner that meets the needs of residents, care plans were generic in nature and did not reflect the resident's wishes or choices. The plans currently in place did not reference all of the residents assessed physical, social, emotional, spiritual or cultural needs and preferences. For example care plans were not in place for the management of seizures for residents with epilepsy or the monitoring and management of diabetes.
In discussions with the person in charge and clinical nurse manager, the inspector was told that a review of the care planning process was underway and that a draft process for advanced care planning for end of life care was devised and was awaiting review and sign off by senior clinical specialists and management.

**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 - Minor

**Findings:**
Evidence that the processes in place for the handling of medicines were safe and in accordance with current guidelines and legislation were found and systems were in place for reviewing and monitoring safe medication practices. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and appropriate procedures for the ordering, storing and returning medication including unused and out-of-date medicines.

Observation of medication administration practice was satisfactory with staff taking time to explain what medications were being given and encourage residents to take their medication, however where residents refused despite repeated offers this was documented and where this raised concerns discussed with the GP and other allied health professionals as appropriate. A record of nursing staff signatures and initials were maintained in line with best practice

In the sample of medication prescriptions and administration records reviewed it was noted that these were, in general in line with best practice, however improvements in relation to prescriptions of "as required" (PRN) medication were required to ensure the maximum dosage within a 24 hour period was identified on all PRN medications. It was also noted that where medications were crushed this was not identified or signed by the prescriber however, the inspector was told that the onsite pharmacist provided guidance to nursing staff on the appropriateness of medications which could be crushed.

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management
Judgement:
Non Compliant - Minor

Findings:
A written statement of purpose was available which broadly reflected the service provided in the centre. On review it was found that some improvements were required to ensure the document contained all of the information required by Schedule 1 of the Regulations.

Information which requires to be included in the statement of purpose includes:
- the specific care and support needs the centre intends to meet
- criteria used for admission
- size and primary function of all rooms
- organisational structure
- details of any specific therapeutic techniques used and arrangements made for their supervision;
- the arrangements for residents to access education, training and employment.

It was also noted that aspects of resident's personal information was included in the document and represents a potential breach of their privacy, dignity and rights to protection of confidentiality under the Data Protection Act 1988 & 2003.

It was also noted that not all residents or their representatives had been provided with a copy of the statement of purpose.

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 - Major

Findings:
The inspector formed the view that within the centre there was evidence of effective management systems to support and promote the delivery of safe, quality care services however, this centre formed part of a larger service provider with a complex management structure and associated levels and lines of authority and accountability. These lines of accountability were not clear to inspectors. Additionally, the person in charge and nominee provider referred to many people with responsibility for clinical
The provider and the person in charge had a comprehensive knowledge about the centre. However, these persons did not have a complete understanding of their roles and legal responsibilities in relation to the overall governance and management of the centre under Regulations. For example, decisions regarding areas such as supervision of residents at night time, admissions/discharges and staffing resources were made by other members of the management team other than the person in charge. The inspectors discussed the roles and responsibilities of the provider and person in charge during the feedback meeting at the end of the inspection.

The centre was managed by a full time skilled and experienced person in charge who demonstrated good leadership skills and sufficient knowledge to ensure suitable and safe care was delivered to residents. The person in charge was supported by a clinical nurse manager who deputised in her absence. All staff and in particular the person in charge and clinical nurse manager displayed an in-depth knowledge and interest in all of the residents. They were familiar with each resident’s personal social medical and clinical interests, background, history and current status. All resident’s were familiar with the person in charge on sight, although few could remember or say her name, the warmth of reaction invoked by her presence indicated mutually respectful and caring interpersonal relationships.

In conversations with them the person in charge and clinical nurse manager both verbalised their ongoing commitment to engage in active and assertive advocacy to promote and protect resident’s rights.

Staff told the inspector that regular staff meetings were held usually on a monthly basis. These provided staff with an opportunity to discuss areas of interest or concern in relation to the daily working and management of the centre. Dates of meetings were notified in advance and staff were invited to contribute items to the agenda for discussion. In conversations at various times throughout the day it was clear that all staff were well informed on areas affecting the centre such as; discussions around the appropriate involvement of residents in simulated fire drills, restraints, training needs.

Throughout the visit the person in charge was observed to give appropriate guidance and direction to staff in relation to the care needs of residents.

**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
**Judgement:**
Non Compliant - Moderate

**Findings:**
The inspector found that at the time of this inspection, the levels and skill mix of staff were sufficient to meet the needs of residents and staff were supervised appropriate to their role. Staffing deployment strategies involved teams of staff allocated to each of the units within the centre consisting of nurses, and care staff allocated to a specific number of residents on a daily basis.

The inspector observed staff and residents interactions and found that staff were respectful patient and attentive to residents needs. It was noted that staff provided reassurance to residents by delivering care to them in a quiet confident manner.

Inspectors checked the staff rota and found that improvements were required. All staff that work in the centre were not included or identified on the roster. Different rostering arrangements pertain within the centre for day and night staff. Allocated day shift staff were rostered by the person in charge and annual leave and other planned/unplanned staff absences were covered from within the existing staffing complement. However, although these allocated staff also rotated onto night shifts, where these staff were absent on planned or unplanned leave, cover was arranged by the night superintendent with responsibility for all centres located on the campus. The person in charge did not control this 'relief' staff roster and was not informed as to who was providing cover for unfilled shifts. Additionally, a daily twilight shift from 20:00 to 23:00 hours was managed by the night superintendent without the involvement of the person in charge. This 'dual' rostering arrangement raised concern regarding the consistency of care delivered to residents and also in terms of governance given that the person in charge had no involvement in this process. Furthermore the inspector became aware that there were occasions on night shift when members of staff may be removed from the centre to fill a shortfall in staffing elsewhere and again this practice raises concerns from the perspective of delivery of a safe and suitable level of care.

Evidence that all staff received up-to-date mandatory fire training was not available. Although all staff training files were not reviewed, inspectors learned that fire safety training had not been delivered to staff on an annual basis as required under Health and Safety legislation. It was further noted that fire safety management procedures and fire drills were not carried out at regular intervals as required by the regulations.

A sample of staff files were reviewed and were found to meet the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons with Disabilities) Regulations 2013. Records reviewed demonstrated that there were effective recruitment procedures in place, volunteers and agency staff were appropriately vetted and relevant members of staff had up-to-date registration with the relevant professional body as required for their role.
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:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
## Provider's response to inspection report

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<tr>
<td>Date of Inspection:</td>
<td>10 March 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>30 April 2014</td>
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### 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 plans currently in place did not reference all of the residents assessed physical, social, emotional, spiritual or cultural needs and preferences.

**Action Required:**

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

All care plans reflect the medical needs of each service user which corresponds in their medical file. Our new advance care plan for end of life care has an assessment and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
recording tool for social, emotional, spiritual and cultural needs and preferences including both service user and family wishes.

<table>
<thead>
<tr>
<th>Proposed Timescale: 30/04/2014</th>
<th>Theme: Effective Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</td>
<td>Plans were not always reviewed in response to changes in residents’ health.</td>
</tr>
<tr>
<td>Action Required:</td>
<td>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.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>All care plans are evaluated and reviewed in response to each service user’s change in health. This is done following daily GP visit or in accordance to nursing observations on each service user on a daily basis or as appropriate.</td>
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<tr>
<td>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</td>
<td>Needs assessments and care plans were not always linked or revised in all instances to determine their effectiveness.</td>
</tr>
<tr>
<td>Action Required:</td>
<td>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.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>Individual health needs are now identified in each service users emerging nursing goal of the care plan. Each health goal is reviewed and evaluated thus determining if the goal needs to be on-going or can be signed off as complete.</td>
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</table>

| Proposed Timescale: 30/04/2014 |
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:
Regular and annual training for staff in fire safety and evacuation was not provided in 2013 or to date in 2014.

Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
Fire training is currently in place and ongoing.

Evacuation of service Users has been carried out during day and night. All staff are responsible to familiarise themselves with the Policy on Emergency plan, this is done with a sign sheet when policy has been read by each staff, morning meetings, diary, communication book.

Proposed Timescale: 01/07/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire safety procedures and fire drills to assess competency and confidence in relation to fire evacuation procedures had not taken place.

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:
Fire evacuation procedure carried out day/night. Day was carried out 12th of March 2014, and by night was carried out 14th of March 2014.

Proposed Timescale: 30/04/2014
### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
End of life or comfort care plans were generic in nature and did not reflect the resident's wishes or choices.

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

**Please state the actions you have taken or are planning to take:**
Individual health needs are now identified in each service users emerging nursing goal of the care plan. Each health goal is reviewed and evaluated thus determining if the goal needs to be on-going or can be signed off as complete.

**Proposed Timescale:** 30/04/2014

### Outcome 12. Medication Management

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The maximum dosage within a 24 hour period was not identified on all pro re nata medications. Some Medications were crushed and this was not identified or signed by the prescriber.

**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:**
Discussion has taken place with GP and Psychiatric Consultant to ensure the dose of all pro re nata medications have a maximum dose specified and any crushed medications are signed off in special considerations of MPAR by the doctor.

**Proposed Timescale:** 30/04/2014
# Outcome 13: Statement of Purpose

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all information required in Schedule 1 of the Regulations was included in the Statement of Purpose.

**Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
There is an up-dated statement of purpose available in both units.

**Proposed Timescale:** 30/04/2014

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**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all residents or their representatives had been provided with a copy of the statement of purpose.

**Action Required:**
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

**Please state the actions you have taken or are planning to take:**
Statement of purpose is available for families, friends, Service Users. All family members have been sent a copy of our statement of purpose. A copy is available on both units on public display.

**Proposed Timescale:** 30/04/2014

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**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Aspects of resident's personal information was included in the document and represents a potential breach of their privacy, dignity and rights to protection of confidentiality under the Data Protection Act 1988 & 2003.

**Action Required:**
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the
statement of purpose at intervals of not less than one year.

**Please state the actions you have taken or are planning to take:**
All service users personal information has been removed from the statement of purpose.

**Proposed Timescale:** 30/04/2014

### 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:**
The management structure in place did not clearly define the lines of authority and accountability, specific roles and responsibilities and did not provide sufficient details on the responsibilities for all areas of service provision.

**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:**
Currently the Centre has an organisational structure chart, and a service organisational structure chart. At centre level the roster for the person participating in management for day/night duty, the nominee provider the CNM3 on campus and the Person In Charge is circulated each week roster. The roles and responsibilities of the persons participating in management are clearly outlined in their job descriptions.

**Proposed Timescale:** 30/04/2014

### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff that work in the centre were not included or identified on the roster.

**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:**
All staff working day and night duty in the unit is now reflected in our duty roster.
**Proposed Timescale:** 30/04/2014  
**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Responsibility for rostering arrangements in place were not sufficiently robust to ensure continuity of care for residents and do not enable the person in charge to be accountable for the standard of care delivery to residents on night/twilight shifts.

**Action Required:**  
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**Please state the actions you have taken or are planning to take:**  
The current duty roster displays all staff on duty from a 24 hour perspective.

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**Proposed Timescale:** 30/04/2014  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Evidence that all staff received up-to-date mandatory fire training was not available.

**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:**  
To date, day and night staff, except three staff members, have received mandatory fire training. The remaining three staff will be trained 11th of June 2014.

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**Proposed Timescale:** 11/06/2014