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:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003942
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	John O'Callaghan
Lead inspector:	Julie Hennessy
Support inspector(s):	Gemma O' Flynn, Paul Dunbar
Type of inspection	Announced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	1

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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
14 October 2014 09:00	14 October 2014 17:30
15 October 2014 09:00	15 October 2014 16:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This report sets out the findings of an announced inspection following an application by the provider to register the centre. This was the first inspection of the centre by the Authority.

Inspectors met with residents, staff members, the person in charge, the provider nominee, the clinical nurse manager (CNM) and other members of the management team. The centre comprises three houses in residential community settings. The centre may accommodate a total of 15 residents and there was one vacancy at the time of inspection.

Inspectors found evidence of good practice across all outcomes. The provider nominee demonstrated a commitment to the regulatory process. The person in charge was a suitably qualified and experienced person. There was evidence of good governance and management in a number of key areas. The provider nominee had completed unannounced visits to each house within the centre and there was evidence that these visits contributed to improving the quality and safety of the service for residents.

Inspectors found evidence of a person-centred approach being promoted that was respectful of the residents' abilities. Residents were supported to pursue educational, training and employment opportunities and their independence was maximised. Staff interacted with residents in an appropriate, warm and friendly manner. Residents confirmed that they felt happy and safe in the centre and that they were involved in any care decisions and in the running of the centre.

Inspectors found that the centre was not in compliance with fire safety legislation; the provider had engaged the services of competent persons in the area of fire safety to complete a risk assessment of each house within the centre and a plan was in place to bring the centre to a level of compliance.

Inspectors found other non-compliances relating to staffing, the premises, documentation, access to multi-disciplinary services, activities for older residents and the statement of purpose, which will be outlined both in the body of this report and 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 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Overall, inspectors were satisfied that residents were consulted with and participated in decisions about their care and the organisation of the centre. However, improvements were required in relation to arrangements for ensuring that the privacy choices of each resident were met. Also, although residents overall had access to activities that were meaningful, improvements were required to the provision of day services for older residents.

Inspectors observed that staff treated residents with dignity and respect and interacted with residents in a warm and appropriate manner. Bedroom doors were kept closed, residents could meet friends and family in private and their personal communications were respected.

There were a number of shared bedrooms in the centre. Although some residents told inspectors that they were happy to share a bedroom, not all residents were happy with this arrangement. One resident had expressed in a pre-inspection questionnaire that she would like her own room. Also, in one house, the en-suite shower in a resident's bedroom was used by another resident. The provider nominee acknowledged that he was aware of these issues and was seeking suitable alternative accommodation for the group of residents in this house.

Inspectors found that residents' independence was maximised in a number of ways. For example, one resident was supported to take her own blood sugar levels and another resident was supported to prepare the meal. On both occasions, staff encouraged residents to do the tasks themselves with the least possible assistance.

Inspectors found that there were times when residents' choices and routines were led by the resources of the service, specifically staffing levels. This will be further discussed and addressed under Outcome 17: Workforce and in the associated action.

Overall, residents had opportunities to participate in meaningful activities. Within the centre; each resident had a personal programme that was tailored to them and involved the development of fundamental life skills including setting the table, loading the dishwasher, promoting personal hygiene, setting the house alarm and managing personal finances. Such skills supported residents to become more independent. Residents told inspectors that they enjoyed going bowling, to the cinema, to the local pub for a drink or dinner or to meet their friends and family. Some residents enjoyed going swimming, to the gym or for a walk. One resident had attended a civic reception for the President. A number of residents told inspectors about participating in recent social outings, including attending a concert during the summer, sports events and events connected to the Limerick City of Culture.

However, inspectors found that although some services were in place for residents who were retired, they were not adequate nor were all services available to all older residents. Although some residents had access to a senior citizens group, not all were able to avail of this service as it was full. Activities for older residents that involved activities such as knitting, baking and arts and crafts were organised several hours per week. Older residents also visited the main campus and participated in meaningful activities or tasks on-campus. However, such arrangements were either too infrequent or insufficient to meet the specific and individual abilities, interests and preferences of older residents. The provider nominee confirmed that the need to develop this part of the service had been previously identified.

Residents were facilitated in exercising their religious rights. Residents' voting preferences were documented.

Residents were consulted as to how the centre was run and minutes of monthly resident house meetings were available to inspectors. Minutes documented that residents were happy in the centre and demonstrated that each resident had an opportunity to contribute to the meeting.

A resident had completed a course in leadership and advocacy in a nearby institute of technology and another resident told the inspector that she also planned to do this course. The CNM3 told the inspector that a resident from one of the houses attended regular advocacy committee meetings. A charter of rights was clearly displayed in the centre.

There were policies and procedures in place for the management of complaints and these were also available in an easy to read version. There was evidence that complaints were documented and that complaints were discussed at staff team meetings and with management if necessary. However, the documentation of complaints did not meet the requirements of the Regulations. For example, whether the complaint was resolved or if the complainant was satisfied was not documented as required by the Regulations.

There was a policy on residents' personal possessions and residents' property was kept safe via appropriate record keeping seen in the residents' personal files. Residents were supported to do their own laundry if they so wished and for some residents the management of laundry had been identified as a life skill to support residents to become more independent or ultimately, to live independently.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Overall, inspectors found that residents' communication needs were respected.

Staff with whom inspectors spoke were aware of the different communication needs of residents. Improvements were required to systems in place to ensure that residents with communication needs had access to appropriate multi-disciplinary team (MDT) services. This will be further discussed under Outcome 11: Healthcare Needs and addressed in the associated action.

There was easy to read versions of organisational literature in place in the house, such as information relating to advocacy, complaints and fire evacuation.

Inspectors were satisfied through observation of staff interactions and the knowledge of staff who spoke with the inspector, that the communication needs of residents were well known to the staff and they were able to discuss the ways in which individual residents communicated.

Residents were made aware of events that were happening in the local community via the local newspaper and residents had access to radio, television and internet services.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community.

Residents' files reviewed by the inspectors included contact details for close family members and friends and other people important to the resident, such as volunteer friends and friends from community groups. The plans also detailed what day residents might speak to a relative or friend and by what means i.e. by phone or video call.

Each resident had a social activities book in which they recorded outings or events they attended. The books included photographs of the residents at the cinema, dancing and bowling. There were also photographs of residents with their friends and family. The residents went out for a meal one evening per week and told inspectors that they very much enjoyed this social occasion.

Inspectors were satisfied that families were involved in personal plans, as appropriate. The person in charge confirmed that the service was reviewing the way in which this was documented.

Positive relationships between the resident and their families and friends were encouraged and supported. Residents told inspectors of how they visited the family home, went out with family for lunch to day trips and spoke to their family members on the telephone and via other social media. Staff supported residents to visit family members if necessary. Some of the residents were on five day contracts at the centre and would spend weekends with their families. Residents visited their friends in other houses or in the community and were supported by staff to make such visits if necessary.

There was no restriction on visitors and residents could meet with visitors in private in the sitting room and/or their own rooms.

Residents were encouraged to maintain links with the wider community. For example, some residents shopped for groceries independently. Other residents met up with friends in a local café. Residents spoke to inspectors about recent social outings which included events connected to the Limerick City of Culture. Residents also told inspectors about how much they enjoyed attending concerts and following sports events.

As previously discussed under Outcome 1: Residents' Rights, Dignity and Consultation, most residents attended day services five days per week where they were involved in a range of activities with their peers.

As part of the volunteer service; some residents had dedicated volunteers or 'friends', who went out with them to socialise or for a coffee. Residents had access to educational opportunities in local educational establishments and this will be elaborated on further under Outcome 10: General Welfare and Development.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that residents' admissions were in line with the centre's Statement of Purpose. The admissions process considered the safety, needs and wishes of the potential resident and also that of those residents already residing in the house. An 'admissions, discharge and transfer committee' was in place and members of the multi-disciplinary team (MDT) sat on this committee to ensure that needs of the resident were adequately reviewed prior to admission.

Inspectors were satisfied that admissions and transfers were safe and planned. Any new admissions involved consultation with the existing residents in the house, the new resident and the resident's family. Staff explained that moves to the centre were planned in a staged manner, for example, residents began by visiting the centre for a cup of tea, followed by a visit to the centre or sleepover, prior to moving into the centre. Staff also confirmed that they monitored the wellbeing of residents with a view to establishing whether they were happy in their current setting.

Each resident had a written contract for the provision of services, which was signed by the resident, a family representative and a representative of the service provider. Inspectors reviewed a sample of contracts and found that they set out the services to be provided, the fees to be charged and the services that incur additional charges.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that residents' wellbeing and social care needs were being met. The arrangements to meet residents' assessed needs were set out in a personal plan, that reflected individual needs, interests and capabilities.

Inspectors reviewed residents' records and found a range of information that was personal and meaningful to each resident. This included information about friends and family, the residents' activity programme, consent forms, holiday details, photographs, voting preferences and information about how choice may be facilitated.

An assessment of needs had been completed for each resident which identified their individual needs and requirements. Additional plans were completed including risk assessments.

Inspectors found that significant work had taken place with respect to personal plans and that further work was underway involving a pilot programme for the roll-out of new personal plans. Inspectors found that each resident had a personal plan. Goals were clearly documented; goals were outcome-focussed, making it easy to determine how each goal contributed to improving the quality of life of the resident; and there was evidence as to how goals were achieved.

There was evidence that residents were fully involved in the development and review of their personal plans. Residents described the contents of their own personal plans to inspectors.

The process involving the review of personal plans was clear and formal reviews took place every six months. An annual report of such reviews was completed by the person in charge for the provider. Such reviews included whether goals were being achieved

and any challenges to achieving set goals. However, although there was evidence of some MDT input, the review of the personal plan was not multi-disciplinary, as required by the Regulations. Findings relating to access to MDT will be further discussed under Outcome 11: Healthcare Needs and addressed in the associated action.

Inspectors found evidence that residents were consulted about being transferred between services and there were supports in place to support any moves. Discharges took place in a planned and safe manner.

Judgment:
Non Compliant - Moderate

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

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Overall, the design and layout of the centre were suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely way.

The centre was found to be homely and well-maintained and promoted residents' safety, independence and wellbeing. There were sufficient furnishings, fixtures and fittings in each house. Residents' photos and artwork were displayed in the house and residents told inspectors that they decorated their rooms themselves. The premises were free from significant hazards on the day of inspection. There was suitable lighting, heating and ventilation. The centre was clean and suitably decorated with adequate communal space. There was a kitchen in each house that was equipped with the necessary equipment.

However, inspectors found that one of the shared bedrooms was not of a suitable size to accommodate two residents. For example, the beds were very close together and one of the beds was not accessible from both sides.

Residents had access to equipment that promoted independence and comfort such as grab rails and shower chairs. Records were available for equipment that required servicing.

Each house had a secure garden and residents told inspectors that they used the

outdoor space when weather permitted.

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):
This was the centre's first inspection by the Authority.

Findings:
Overall, inspectors found that the health and safety of residents, visitors and staff was promoted and protected. However, the centre was not in compliance with fire safety legislation and improvements were required to the evacuation procedure.

The centre had an up-to-date safety statement and risk management policy. There were other policies and guidance documents in place relevant to health and safety and risk management, including in relation to infection control, incident recording and reporting and food safety.

The centre was not in compliance with fire safety legislation; the provider nominee had submitted a fire risk assessment to the Authority, which had been undertaken by persons competent in the area of fire safety. The risk assessment outlined recommendations of works to be completed to make the centre compliant with relevant legislation.

Suitable fire equipment was available and service records were available and were found to be up-to-date. There was adequate means of escape and daily checks were undertaken and recorded to ensure that exits were unobstructed. There was a prominently displayed fire evacuation plan displayed in the centre and a personal emergency evacuation plan was displayed adjacent to the evacuation plan.

Regular practice fire drills took place in the centre and were documented, as required by the Regulations. However, there was room for improvement in relation to the documentation of fire drills. Although practice fire drills were completed and recorded, some records did not specify the time taken to evacuate the centre or clearly outline the actions required to address any issues identified during a practice fire drill.

There was a prominently displayed evacuation plan and procedure in each house. However, some improvements were required to the evacuation procedure. Although staff were able to clearly describe how to evacuate the centre in the event of a fire, the evacuation procedure did not adequately capture the mobility and cognitive needs of residents.

An incident report form was completed for any accident or near-miss incident. There was evidence that incidents were discussed with staff at house level. However, although incidents were being recorded and reported, improvements were required to ensure learning from such processes. For example, an understanding of incident investigation and the importance of adopting a non-punitive approach to incidents was not demonstrated, as is necessary to ensure that there are no barriers to the reporting of errors and that the root cause of the incident is correctly identified.

Hazard inspections had recently commenced within the centre. There were up-to-date risk assessments in place.

There was general cleaning guidance and cleaning standards in place. Inspectors spoke with staff who were able to identify hand hygiene as an important means of infection control and were able to identify when and how to wash their hands. Information was available in relation to the prevention of infectious diseases and health promotion.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that systems were in place to protect residents from being harmed or suffering abuse. A positive approach to behaviour that challenges was demonstrated. There were no restrictive practices in place in the centre. Improvements were required to the documentation pertaining to behaviour that challenges.

There were organisational policies in place in relation to the protection of vulnerable adults and behaviour that challenges.

Inspectors viewed training records that confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Inspectors spoke with staff who were knowledgeable of what constitutes abuse and of the importance of

reporting an incident, suspicion or allegation of abuse.

Inspectors spoke with residents who confirmed that they felt safe in the centre and that knew who to talk to if they needed to report any concerns of abuse. There was a nominated person to manage any incidents, allegations or suspicions of abuse and staff were able to identify the nominated person.

Inspectors reviewed documentation and spoke with staff in relation to behaviour that challenges. Inspectors found evidence of a positive approach to behaviour that challenges with clear referral systems. There was evidence that MDT input had been sought for individual residents. Residents were involved in discussions and reviews that had been arranged to support them to manage their own behaviours and consent was documented for supports in place.

However, inspectors found that the documentation was disjointed and kept in a number of different locations making it difficult to ensure that staff had all of the information they needed in order to support a resident with behaviour that challenges. For example; for one resident, information pertaining to antecedents to a specific behaviour was kept in the medical file and guidance for staff was kept in another file. Also, although staff were able to articulate how to manage specific behaviours that challenge, the written guidance was not specific enough to direct any staff who would not know the resident well. Inspectors found that the risk assessment template contained in the organisation's own policy for the management of behaviours that challenge had not been used, although it provided the format to sufficiently capture all of the information that staff might need. This will be further discussed under Outcome 18: Records and Documentation and in the associated action.

Inspectors found that there were two training programmes in place relating to the management of behaviour that challenges. Although all staff had attended one training programme, this training did not meet the Regulatory requirements as it did not include de-escalation and intervention techniques. This will be further discussed under Outcome 17: Workforce and in the associated action.

The inspector reviewed arrangements in place for managing residents' finances and found a clear and transparent system in place. Residents were involved in the management of their own finances, as far as reasonably practicable. The inspector reviewed a sample of records and found a clear system of logging and tracking of all transactions, with receipts and records and an auditing system in place.

Judgment:
Compliant

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
A record of all incidents occurring in the designated centre was being maintained and where required, notified to the Chief Inspector. Quarterly reports were provided as required.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Residents had opportunities for new experiences, social participation, education, training and employment. Continuity of education, training and employment were maintained for residents in transition. Improvements were required to the assessment process.

Although inspectors found that residents participated in education, training and employment; a formal assessment of each resident's educational, employment and training goals were not maintained in the designated centre. The provider was in the process of addressing this and a draft education policy had been completed within the organisation, which included an assessment tool for this purpose.

The organisation had established links with education, training and employment providers including the local university, institute of technology, adult education and colleges of education. As previously mentioned under Outcome 1: Residents Rights,

Dignity and Consultation; a resident had completed a course in leadership and advocacy in a nearby institute of technology and another resident expressed interest in completing this course in the near future. A resident participated in the graduate entry medical school in the nearby university. There was evidence of engagement between the service and universities, for example, one institution had engaged the assistance of the residents to help develop an app which would aid communication for people with disabilities.

Inspectors spoke with residents who confirmed that they were happy with the options available to them. Inspectors found that the range of opportunities were appropriate to residents' abilities and interests and meaningful to them.

Residents were encouraged to request training or support in certain skills and these were actively followed up by staff. Staff were also appraised of any new courses or training which may be taking place at a day service and made this information available to residents.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that residents were supported on an individual basis to achieve and enjoy good health. However, inspectors found that not all MDT services were readily accessible. Also, improvements were required to documentation.

Inspectors reviewed residents' personal plans as they related to healthcare and found that residents had timely access to their own general practitioner (GP) and access to other medical professionals as required. Inspectors found that residents had access to medical treatments where recommended, including ongoing monitoring of blood tests and scans. Regular screening took place. Inspectors found that residents had access to some allied health services and viewed referrals to an optician, psychologist and dietician. However, not all health services were readily accessible. Some residents had not been seen by a dentist for a number of years. One resident had never been seen by a speech and language therapist, despite having significant communication needs.

Inspectors found that the health of residents was monitored on an ongoing basis and

viewed records of monthly checks completed by staff and forwarded to the CNM. Such checks included monitoring of blood pressure and the weight of residents.

Residents' consent was documented in relation to different aspects of healthcare including who can give consent to attend medical or hospital appointments and consent by the resident to have bloods taken. There was evidence that a residents' right to refuse treatment was respected.

However, improvements were required to healthcare documentation. An intimate care plan had not been completed for one resident who needed assistance with her personal care. Also, some information was inconsistent. For example, one document said that a resident could eat without assistance, whereas another document said that the resident's food needed to be prepared in a specific way, which was important guidance to ensure that the resident's independence was maximised. Inspectors spoke with staff who were clear about what guidance to follow in order. This will be addressed as a documentation issue under Outcome 18: Records and Documentation.

Residents were encouraged and supported to make healthy choices. Inspectors viewed information relating to healthy eating, teeth brushing and hand hygiene. Residents had individual exercise programmes, which were encouraged by staff and which residents confirmed that they enjoyed.

The person in charge outlined how the GP was very supportive in relation to providing information about specific dietary needs. There was evidence of input from a dietician in a number of personal plans. Staff were knowledgeable about how to implement dietary plans.

Each house had a kitchen and dining area which were homely, comfortable and clean. Residents were involved in planning for the weekly shop, in preparing the weekly menu and in other kitchen tasks. However, although residents in two houses were involved in meal preparation; in the third house this was not the case and the person in charge did not offer a clear explanation for this discrepancy.

The fridge was well stocked and there was a plentiful supply of fruit and vegetables in the house. Staff were knowledgeable about residents' likes, dislikes and preferences, which were documented. Residents had access to snacks throughout the day. Any assistance offered was done so discreetly.

Inspectors observed meals that had been prepared for dinner in each house and noted that it appeared nutritious and healthy. Dinner was a sociable and relaxed occasion.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Overall, inspectors found that residents were protected by safe medication management policies and practices.

There was a written policy in place relating to the ordering, prescribing, storing, administration and disposal of medications. However, the shared sticker system in place in the centre was not referenced in the policy, nor was it implemented in practice. The need to address this issue at policy-level will be further addressed in Outcome 18: Records and Documentation to be kept at a Designated Centre and in the associated action.

An inspector reviewed residents' files and found that individual medication plans were appropriately implemented and reviewed as part of the personal plan review process. Information relating to each resident's medication was maintained in their file in an easy-to-read format.

Prescription charts and administration charts were completed in line with relevant professional guidelines and legislation. All medications were individually prescribed. The inspectors noted that the maximum dosage of PRN ("as required") medications was prescribed and all medications were regularly reviewed by the GP. Support was also provided by the GP in relation to any new medications or queries that staff had in relation to the use of any medications.

There were no residents prescribed controlled medications at the time of inspection.

Residents were supported to manage certain aspects of their own medication, as appropriate to their individual capabilities and wishes. An assessment had been completed for any resident who was involved in managing aspects of their own medication.

Unused and out of date medications were secure and segregated from other medicinal products, as required by the Regulations and a record of returns to pharmacy was maintained.

Medication errors were recorded and reported. There was evidence that medication errors were discussed at meetings between the CNMs and that information relating to

errors was used to identify issues or trends.

Audits of every house within the centre were completed at a minimum annually by a CNM and a representative from the pharmacy also completed annual audits. Inspectors reviewed completed audits and found that they were comprehensive and identified actions to be taken. Audit results were reviewed by the Drugs and Therapeutics committee.

Judgment:
Compliant

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

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The statement of purpose consisted of a statement of the aims of the centre and a statement as to the facilities and services to be provided for residents. The statement of purpose was kept under review and was available to the residents.

Although the statement of purpose contained most of the information required by Schedule 1 of the Regulations, some information was too broad to accurately reflect the services provided by the centre, including in relation to the specific care and support needs that the designated centre is intended to meet, the type of nursing care provided and the criteria used for admission to the designated service. Also, the size of the rooms was not specified, as required by Schedule 1 of the Regulations.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that there was an effective management system in place, clearly defined management structures and the person in charge had the required skills, qualifications and experience to manage the designated centre. Issues related to staffing of the designated centre are addressed under Outcome 17: Workforce.

The inspectors found that there was a clearly defined management structure in place in the designated centre. Inspectors spoke with staff and residents and found that staff were clear in relation to lines of authority and residents were able to identify the person in charge.

The person in charge was in a full-time post for two designated centres. The person in charge had the necessary experience and qualifications, as required by the Regulations. The person in charge was aware of the requirement under the Regulations to complete a management course appropriate to her role and was exploring a suitable course. The person in charge visited each house formally weekly and was in contact with the social care leaders within each house informally on a frequent basis and as issues arose.

Residents views were sought and in 2013 all residents were invited to participate in a service satisfaction survey.

The provider nominee had completed unannounced visits to the designated centre and a written report arising from such visits was made available to inspectors, as required by the Regulations. Inspectors found evidence that the unannounced visits contributed to improving the quality and safety of the service as the provider nominee had identified many of the areas that require improvement in the service including key areas for development relating to personal planning. Other audits took place within the service including in relation to medication management, fire safety, health and safety and hygiene.

There was a system in place for carrying out an annual review of the quality and safety of care of the service. The inspector reviewed a copy of the review, which had been

completed by the quality and risk officer. The review included audits carried out in the previous 12 months and a report on progress on any necessary actions. The inspector found that the review contributed to improving the quality and safety of care of the service.

The provider outlined the types of arrangements in place relevant to the designated centre that ensured staff were facilitated to discuss issues relating to safety and quality of care and that staff could exercise their responsibility for the quality and safety of the services that they delivered. House meetings were held every three months and attended by the person in charge. Staff confirmed these meetings took place and inspectors reviewed minutes of such meetings. Meetings between social care leaders (who supervise each house on a day to day basis) and the provider took place six times a year. Full service meetings took place three times a year and took the form of an open forum that all staff were encouraged to attend. Weekly management team meetings also took place that included the provider, the person in charge and clinical nurse managers.

The provider told inspectors that staff appraisals were completed on an annual basis and this was confirmed by staff. Records of staff appraisal were maintained on staff files.

Judgment:
Compliant

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There had not been any occasions where the person in charge was absent for 28 days or more from the centre.

There were support structures and staff in place for times that the person in charge was not in the centre, including support by a social care leader in each house, a CNM3 dedicated to oversee the centre and a CNM3 on call for the service outside of normal working hours.

Formal arrangements were in place that identified a specific deputising arrangement for any notifiable absence of the person in charge with the CNM3 deputising in the absence of the person in charge during such times.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that resources were allocated to the designated centre, including for any repairs, the servicing of equipment and the upkeep of the houses. Overall, the centre was sufficiently resourced to ensure effective delivery of safe care in line with the SOP.

However, inspectors found that a review of human resources in the designated centre was required. Inspectors identified gaps relating to staffing, which are discussed under Outcome 18: Workforce and in the associated action.

Judgment:
Compliant

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors found that the staffing levels were not always sufficient in the designated centre. This was discussed with the provider nominee who outlined steps that either had

been taken or were being taken to address this non-compliance. Staff had access to education and training. There were systems in place relating to the recruitment, selection and vetting of staff. Volunteers were supervised appropriate to their role.

Inspectors found evidence that the staffing levels were not always sufficient in the designated centre. The number of staff in one house was insufficient three days per week, which had an impact on residents. For example, one resident could not always go for a walk during such days, as specified as a goal in her personal plan. Also, contingency plans in place to cover staff who took leave at short notice were insufficient. Finally, inspectors found that residents' choice and routines were being dictated by staffing levels. For example, residents did not have the choice to have a lie-in in the morning as staff were not available to facilitate this. The inspector discussed staffing levels with the provider nominee who confirmed that he was aware of such issues and demonstrated that steps had been taken to address the issues identified. Such steps included exploring how to increase the numbers of relief and agency staff that the service could access when necessary. Also, a new staff member was due to start in one house in November, to ensure that residents' could meet their goals and participate in activities that they enjoy.

Inspectors found that there was an accurate staffing roster showing staff on duty which included the times that all staff were on duty. The provider nominee outlined how protected hours for social care leaders of three hours per week had been introduced in the preceding weeks to support the person in charge in meeting regulatory requirements, particularly in relation to the need to improve residents' personal plans.

There was a training plan in place for 2014. The annual staff appraisal system facilitated the identification of staff training needs. Inspectors spoke with staff who confirmed what training they had received and records of training were reviewed. However, as previously mentioned, inspectors found that not all mandatory training had been provided in accordance with the Regulations, specifically in relation to behaviour that challenges.

Staff had completed other training or instruction relevant to their roles and responsibilities including in relation to hand hygiene, safe moving and handling, food safety and specific topics such as ageing and intellectual disability, the management of diabetes and the identification and management of dysphagia. Training had taken place recently in relation to medication management.

Staff were aware of the Regulations and Standards. Inspectors noted that the organisation had held information and training sessions for staff and management in relation to the Regulations and Standards, in accordance with their roles and responsibilities.

There was a system in place for the management of volunteers within the organisation, which was overseen by the volunteer coordinator. There was a volunteer policy in place which clearly set out the roles and responsibilities of volunteers in writing; all volunteers provided a vetting disclosure; volunteers were interviewed prior to commencing as a volunteer; three references were sought for each volunteer and; there was a clear training and supervision system in place.

Staff appraisals were completed on an annual basis and staff confirmed that such appraisals took place.

Staff files were not reviewed on this inspection. However, files were reviewed a number of occasions in recent months and the Authority were satisfied that there was a robust system and audit procedure in place to ensure completeness of files as required in Schedule 2 of the Regulations.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
At organisational level, significant work had taken place in relation to policies required under Schedule 5 of the Regulations in the preceding months. Improvements were required to records and documentation to ensure completeness, accuracy and ease of retrieval.

A directory of residents was maintained in the centre and this contained all of the items required by the Regulations. The centre was adequately insured against accidents to residents, staff and visitors.

A record of residents' assessment of need and a copy of their personal plan was available. The inspector found that a record of nursing and medical care provided to the resident including any treatment or intervention was maintained. However, improvement was required to records in respect of each resident. For example, as previously discussed under Outcome 8: Safeguarding and Safety; documentation pertaining to the management of behaviour that challenges was not complete or easily retrievable. Also, as previously discussed under Outcome 11: Healthcare Needs; health information was inconsistent or not sufficiently detailed to guide the care and support that the resident

required.

Records relating to money or valuables, other personal possessions, notifications and staff rotas were maintained, stored securely and were easily retrievable.

A significant amount of work had taken place in relation to the development of policies at organisational level in the preceding months. The majority of policies required under Schedule 5 of the Regulations were in place. One outstanding Schedule 5 policy was in draft format; 'access to education, training and development'. However, as previously mentioned under Outcome 12: Medication Management; the shared sticker system in place in the centre was not referenced in the medication management policy, nor was it implemented in practice.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003942
Date of Inspection:	14 October 2014
Date of response:	20 November 2014

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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to ensuring that the privacy needs and wishes of each resident were met: the en-suite shower in a resident's bedroom was used by another resident and; a resident who shared a bedroom expressed that she would like her own room.

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

Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
Plan to address the sharing of en-suite shower has been discussed with the Service Engineer Officer and work will be undertaken to address this in the Centre. Since the Registration Inspection the PIC has consulted with each resident who shares a bedroom in the Centre to clarify their expressed wishes. It is now determined that each resident is currently content to share their bedroom and this has been recorded in their Personal Plans.

Proposed Timescale: 31/03/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Activities for older residents were not sufficient to meet the specific and individual abilities, interests and preferences of all older residents.

Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
Two additional risk funded posts have been authorised by the Service Provider. A menu of options and choices for each of the older residents will be put in place and a timetable of activities appropriate to their needs identified. The PIC will work in consultation with all available resources including Day Services to formulate this programme.

Proposed Timescale: 30/01/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documentation of complaints did not meet the requirements of the Regulations. For example, whether the complaint was resolved or if the complainant was satisfied was not documented as required by the Regulations.

Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
A suitable complaints Log is being drafted by the Service and this will account for how the complaint was resolved and if the complainant was satisfied with the outcome.

Proposed Timescale: 01/01/2015

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 review of the personal plan was not multi-disciplinary, as required by the Regulations.

Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
The requirement for personal plans to be reviewed by the multi-disciplinary team (MDT) was discussed at the Service Regional Management Meeting on 24th October 2014. It was agreed that provision for a written report by the relevant MDT would be put in place as part of the annual review of the personal plans.

Proposed Timescale: 31/10/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises did not fully meet the requirements of the Schedule 6 of the Regulations. For example, one shared bedroom was not of a suitable size and the shower facilities were not sufficient to meet the needs of residents in one house.

Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
A medium term plan to find alternative accommodation for the residents in question has commenced which will involve securing appropriate capital grants to purchase a suitable premises. Plan to address the sharing of en-suite shower has been discussed with the Service Engineer Officer and work will be undertaken to address this in the Centre.

Proposed Timescale: 30/11/2015

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:
Improvements were required to ensure learning from near-misses, errors and incidents involving residents.

Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
In support of the Service Risk Management and Incident Reporting Policy, further training for Managers will be delivered to ensure there is an understanding of incident investigation and that a non-punitive approach to incident investigation is demonstrated.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The evacuation procedure did not adequately capture the mobility and cognitive status of residents.

Action Required:
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

Please state the actions you have taken or are planning to take:
The evacuation procedures for each resident will be updated to ensure their mobility and cognitive status is taken into account. The procedures will be displayed in a prominent place in the Centre.

Proposed Timescale: 30/11/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not in compliance with fire safety legislation.

Action Required:

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

Please state the actions you have taken or are planning to take:
Service Engineer and Health & Safety Officer, working in consultation with a qualified Fire Consultant, has identified priority works to be completed to ensure all houses are fire compliant. The plan of works needs to be costed by 30th November 2014 and a proposed timescale to address this to be completed by 27th February 2015.

Proposed Timescale: 27/02/2015

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:
Not all health services were readily accessible. For example, some residents had not been seen by a dentist for a number of years and; a resident had never been seen by a speech and language therapist, despite having significant communication needs.

Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
The dental list for all residents will be reviewed and referrals will be forwarded as appropriate for dental supports. PIC will resend referral for resident who had not been seen by speech and language therapist and determine a plan of support.

Proposed Timescale: 12/11/2014

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 of the information required by Schedule 1 of the Regulations was contained 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:

The Statement of Purpose will be amended to reflect the recommendations as highlighted by the HIQA Chief Inspector.

Proposed Timescale: 19/12/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing levels were not always sufficient in the designated centre. The contingency plans in place to cover staff who took leave at short notice were insufficient; the number of staff in one house was insufficient three days per week, which had an impact on residents and; residents' choice and routines were being dictated by staffing levels.

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:
Staffing levels within the Centre will be reviewed by the Nominee Provider to ensure there is a robust contingency plan to cover staff who take leave at short notice. New Intern Care Assistant Posts are currently being processed and will be deployed to address the staffing levels also. A plan to address the shortfall of 3 days in one house has been put in place.

Proposed Timescale: 31/01/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all mandatory training had been provided in accordance with the Regulations, specifically in relation to behaviour that challenges.

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:
The content of the Challenging Behaviour Mandatory Training for staff has been amended to include de-escalation and intervention techniques. Training dates for staff have been set for 27th November, and 4th December. Ongoing training for all staff will take place.

Proposed Timescale: 30/06/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The shared sticker system in place in the centre was not referenced in the medication management policy, nor was it implemented in practice.

Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:
An addendum to the Medication Policy has been added to address the issue in relation to the shared sticker system.

Proposed Timescale: 20/10/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to records in respect of each resident. For example, documentation pertaining to the management of behaviour that challenges was not complete or easily retrievable; health information was inconsistent or not sufficiently detailed to guide the care and support that the resident required.

Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
The Registered Provider has clarified the definition of what constitutes Challenging Behaviour in consultation with Service Principal Psychologist and Quality Officer. Where relevant a risk assessment in keeping with the Service Policy on Challenging Behaviour will be put in place. All other support plans will be reviewed with a view to updating the content of the plans to ensure they are sufficiently detailed to guide the care and support for each resident.

Proposed Timescale: 30/11/2015