**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 St John of God Community Services Limited |
| **Centre ID:** | OSV-0002883 |
| **Centre county:** | Co. Dublin |
| **Type of centre:** | Health Act 2004 Section 38 Arrangement |
| **Registered provider:** | St John of God Community Services Limited |
| **Provider Nominee:** | Bernadette Shevlin |
| **Lead inspector:** | Julie Pryce |
| **Support inspector(s):** | None |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 6 |
| **Number of vacancies on the date of inspection:** | 0 |

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

**Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 04 March 2015 10:30 | 04 March 2015 20:00 |

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

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|---|
| 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 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |

**Summary of findings from this inspection**

This was an unannounced inspection of a community based designated centre operated by St. John of Gods Community Services Limited. The purpose of this inspection was to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013) (hereafter called the Regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the Standards).

As part of this inspection, the inspector met with the person in charge, staff and residents. The inspector observed practice and reviewed documentation such as personal plans, healthcare plans, accident and incident records, risk assessments, medication records, meeting minutes, policies, procedures and protocols, governance and management documentation, staff training records and staff files.

Six residents resided in this designated centre which was a large and spacious bungalow. Overall the inspector found that residents had a good quality of life, and that their health and social care needs were met.

Some improvements were required for example, in personal planning, premises, medication management, and consistency of staffing levels. These areas are

discussed in the body of the report and in the action plan at the end of the report.

**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

**Outcome 05: Social Care Needs**

*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**
Effective Services

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

**Findings:**
Personal plans were available for all residents, and each plan began with a 'Personal passport' which included the most important information about the person. Health needs assessments were in place which identified the healthcare needs of each resident. However, these assessments did not lead to a plan of care for all the assessed needs reviewed during the course of the inspection, for example there was no plan of care relating to long term pain control for one of the residents, or for the care relating to an acute infection, as further discussed under Outcome 11.

The inspector was concerned that there was no assessment of social needs in place from which to determine what would constitute a meaningful day for each person. While a schedule of events was in place there was insufficient evidence was in place there was no evidence that these activities reflected residents' choice and interests. In addition there was no evidence that people were being taught new skills, and insufficient evidence to indicate that the potential of residents was being maximised in accordance with the regulations. For example, one of the residents had been identified as requiring training in the use of computerised tablet device, however, this training had not been provided at time of inspection.

Implementation of personal plans was not recorded for all residents, for example there was no record of the phased introduction of orthotics for one resident, or of the introduction of objects of reference to assist with communication for another. The inspector was concerned as to how the effectiveness of the plan could be assessed where the implementation was not recorded.

**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:**
The inspector was concerned that the premises of the designated centre were not designed and laid out to support the needs of residents.

Some modifications had been made to the living areas in accordance with the assessed needs of residents. For example, safeguarding was in place in the bedrooms of those residents who might have seizures and were at risk of injury from fixtures and fittings.

However, the layout of the building was inappropriate to accommodate the number and needs of residents. The only access of one resident to his bathroom and bedroom was via one of two bedrooms occupied by other residents.

Staff were aware of the inappropriateness of the arrangement, and accommodated the privacy needs of residents as best they could under the circumstances. In addition the organisation had plans to extend and rectify the living accommodation, and a satisfactory timeframe was submitted to the Authority following the inspection.

Some other areas of the living accommodation were appropriate to the needs of residents, for example, one resident had a spacious and comfortable bedroom with an en-suite bathroom. However, there were files and documents stored in the kitchen and living areas in open cabinets that were not conducive to a homely environment.

In addition, the outside area of the home was not appropriately maintained. Whilst the front of the property was a pleasant landscaped area, the back outside area was in need of maintenance, for example, the extensive fencing was not well maintained and in need of repainting or removal. There was also an area which had been identified as being unsafe due to unstable flagstones which was blocked off from use with plastic garden chairs.

**Judgment:**

Substantially Compliant

**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:**
The inspector found that systems were in place for the prevention and detection of fire. The training records examined showed that there was regular fire safety training for the staff and that fire drills were conducted. The inspector found that staff were aware of the fire evacuation procedures and were able to describe the procedures involved. There was a personal evacuation plan in place for all residents, all fire safety equipment had been tested regularly, and a fire safety audit had been conducted which outlined required actions and the person responsible for these.

There were some risk assessments in place, for example, in relation to restrictive interventions. A risk register was in place and there was a system for the escalation of any risks which could not be managed locally. A red risk reviewed by the inspector had been responded to in a timely and appropriate fashion, and the actions required to reduce the risk had been implemented. However, not all risks identified in the centre had satisfactory management systems in place. For example, the risk of a medical emergency for one resident was being managed by the use of a CCTV linked to a monitor in the staff area. This monitor was not consistently observed, and the inspector was concerned that this system would not alert staff to an emergency. This was rectified in the course of the inspection by the Person in Charge who sourced an alarm mat for the resident's bed to more appropriately manage the risk.

Systems were in place in relation to infection control, hand hygiene training had been made available to staff, facilities were readily available, cleaning equipment was appropriately stored and the designated centre was visibly clean.

**Judgment:**
Compliant

**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:**
The provider had put in place systems to promote the safeguarding of residents and to protect them from the risk of abuse. The inspector found that staff were knowledgeable in relation to types of abuse, recognising signs of abuse and their role in the safeguarding of residents.

There was a financial management plan in place for each resident in relation to the management of their spending money, any purchases were recorded with a receipt and a signature. All balances checked by the inspector, including personal money and household finances were correct.

Some improvements were required in the management of restrictive interventions. For example, there was no evidence of alternatives to the use of bedrails having been considered. In addition, a protective helmet was in use for one of the residents, and whilst this had been risk assessed and also referred to the Rights Review Committee, neither the use of this restriction or the use of bedrails were being recorded. The Person in Charge introduced a recording system during the course of the inspection.

**Judgment:**
Substantially 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:**
The inspector found that residents healthcare needs were met for the most part. Residents had access to a General Practitioner (GP) and there was input from other healthcare professionals, for example, speech and language therapists, physiotherapist and occupational therapists. An annual seating assessment was conducted for each resident who required it.

There were plans of care in place for many of the assessed needs of residents, for example, a plan of care in relation to the management of epilepsy for one resident was examined by the inspector and was found to be based on assessed needs and in sufficient detail as to guide staff in the delivery of care. However, whilst staff demonstrated detailed knowledge of residents' healthcare needs, plans were not in place for all these needs, for example, a resident who was on long term pain relief and a resident who had developed an acute infection did not have plans of care in place in relation to these needs, as outlined in Outcome 5.

The inspector was satisfied that residents' nutritional needs were met to an acceptable standard. Meals were planned in advance with the residents at a weekly meeting, and pictures of various meals were available to assist communication. The kitchen was well stocked, and snacks and drinks were readily available. Any recommendations of the speech and language therapist were implemented.

**Judgment:**
Compliant

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**

**Findings:**
While there was evidence of structures and processes in place in relation to the management of medications, some improvements were required.

There was a medication management policy in place and staff were aware of its content, however it stated that a local protocol should be developed in relation to ordering and storage of medication, and this was not in place.

Documentation relating to the management of medications for residents was in place, including prescriptions for 'as required' (PRN) medications and administration recording sheets. However, prescriptions did not all include sufficient guidance, for example medication for one resident was being crushed to aid administration, but it had not been prescribed as such, nor had the pharmacist been involved in the decision to crush the medication.

**Judgment:**

Substantially Compliant

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The inspector was satisfied that there was an appropriate management structure in place which supported the delivery of safe care and services.

The inspector found that the person in charge of the centre was suitably qualified and experienced. She was knowledgeable regarding the requirements of the Regulations and the National Standards for Residential Services for Children and Adults with Disabilities. She was present in the centre on a regular basis and it was clear that she was well known to the residents. She had a very good knowledge of the health and support needs of the residents. She was clear about her roles and responsibilities and about the management and the reporting structure in place in the organisation.

Regular team meetings were held, minutes were maintained of these meetings includeing the agree required actions. Involvement of families in consultation had recently commenced by the introduction of family meetings.
Some audits had been conducted, for example an audit of personal plans and an audit of financial management. These audits included required actions and timeframes and there was evidence of the system of audit having led to improvements in practice. In addition the provider had conducted an unannounced visit within the last six months, which resulted in an action plan.

**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:**
The inspector found that staff were knowledgeable about the individual needs of the residents, and about the organisation of the centre and of their responsibilities under the regulations. All interactions between staff and residents observed by the inspector were caring and respectful, and appropriate to the assessed needs of the individual residents.

The inspector reviewed the staff rosters and observed the daily activities and found that staffing arrangements were not always based on the assessed needs of the residents. For example, there were fewer staff on duty four days of the week. There was no evidence of an assessment of need having informed these staffing levels, and the inspector was concerned that the record of activities showed that activities were curtailed on the days when staffing levels were lower.

There was safe recruitment systems in place to ensure that staff employed in the centre were suitable to work with vulnerable adults. Staff files contained the required documents as outlined in Schedule 2 of the Regulations. Records were maintained of staff training and adequate training had been provided and scheduled for staff.

**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:***

Julie Pryce
Inspector of Social Services
Regulation Directorate

**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 St John of God Community Services Limited |
| **Centre ID:** | OSV-0002883 |
| **Date of Inspection:** | 04 March 2015 |
| **Date of response:** | 08/06/2015 |

## Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

## Outcome 05: Social Care Needs

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Assessments were not comprehensive as they did not include an assessment of social needs.

**Action Required:**

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

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
At present each Resident has a Single Intregrated Support. The information from this plan is being transferred to the " All About Me" document which together with the Using your Environment Assessment will be completed by the 31st July. This assessment will improve the person-centred plan in areas such as Activity and Recreational needs, Communication, Restrictions, Personal Outcome Measures and Skills Teaching.

The comprehensive " All About Me " Plan for three residents will be finalised and in place by the 15th August, 2015.

The remaining three residents will have their " All About Me" plan finalised by the 31st August 2015.

The above plans will have input from staff and multidisciplinary team, family representatives and management.

A pain management plan was developed for residents who required it on the 18/03/2015.

A care plan in line with infection control protocols will be developed for residents where required – 31/05/2015.

The schedule of activities will be reviewed at team meetings to ensure that each resident enjoys a meaningful day. The scheduled activities will reflect resident's choice and interests.

A skills teaching programme has been identified for Residents in conjunction with the Speech and Language Therapy department using their preferred means of Communication "Objects of Reference" and will be fully implemented by 01/07/2015

A skills teaching programme for a Resident identified as requiring training in the use of a computerised tablet device will be in place by the 31/05/2015.

**Proposed Timescale:** 31/08/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans did not reflect all the residents' assessed needs.

**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:**
An audit of each Residents P.C.P. will be carried out by the Supervisor on a Monthly basis until compliance is reached. An individual Personal Tracking form will be put in place by the Supervisor to ensure all elements of the person centred plan are dated, signed and evaluated.

**Proposed Timescale:** 01/07/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans did not outline the supports required to maximise residents' personal development.

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

**Please state the actions you have taken or are planning to take:**
The "All About me" Assessment Tool is a thirty page document, which will generate from every section a support/care plan where needed for both medical and social needs. The document is easy to navigate, clear and precise and is flexible to input more information if needed. This document also reflects the resident's choice and interests and skills teaching.

The Supervisor will review the PCP's bimonthly with each keyworker to monitor progress and implementation of the "All About Me" assessment.

The PCP for their key resident will also be reviewed within Staff's Professional Supervision plan and will be included in Staff's yearly P.D.R.

**Proposed Timescale:** 01/07/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Implementation of personal plans was not recorded so as to inform an assessment of the effectiveness of the plans.

**Action Required:**

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

**Please state the actions you have taken or are planning to take:**
The person-in-charge will ensure that each resident's personal plan will be reviewed annually.
This review will be multi-disciplinary and will take account of the residents changing needs.
The resident and their family or representative will be invited to participate in the review.
Any proposed changes will be carried out and reviewed by the Teamleader and Person-in-Charge.

A management plan was put in place for one resident for the introduction of her orthotics on the 05/03/2015.

**Proposed Timescale:** 01/07/2015

**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 were not designed and laid out to meet the needs of residents.

**Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
Funding has been approved for the Conversion Works in the D.C.
Tender Drawings are being prepared and this will go to tender on the 8.6.2015.
Return of Tender Submissions expected on the 6.7.2015.
Tender report to be drafted and submitted by 13.7.2015.
It is anticipated that work will commence in August 2015 and anticipated completion by 31.12.2015.

Written consent has been obtained from all families for the above improvement works.

**Proposed Timescale:** 31/12/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**
The rear backyard was not maintained in a satisfactory condition.

**Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
The Person-in-Charge has set up bi-monthly meetings with Maintenance Manager and Supervisor to review and prioritise maintenance works in the D.C.

Concrete slabs at the rear of the house will be replaced to make the pathways safe by the 20-05-2015.

Doors will be fitted to the Welsh dresser to cover shelves where PCPs are filed by the 31.05.2015.

All garden furniture, fencing and sheds at the rear of the house will be repaired and painted/wood stained by the 30.06.2015.

The Person-in-Charge will explore options for a community project to revamp the rear gardens at the premises.

The family of one of the Residents has planned a fundraising night for the 19-06-2015. Some funds from this effort will be used to improve the external aspects of the designated centre.

Flower bed wall at the front of the premises will be repaired by the 20-05-2015.

**Proposed Timescale:** 30/06/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was insufficient evidence that all alternatives to restrictions had been considered.

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

**Please state the actions you have taken or are planning to take:**
Tracking sheets have been put in place for all restrictions.

The use of Protective Helmets has been reviewed by the Helmet Committee for the three residents who wear protective helmets. Tracking on use of same has been put in place. Protocols will be put in place for the removal of these Helmets during safe periods e.g. when staff are sitting with the Resident once the review is complete.

One Resident removes her Helmet herself when sitting and puts it on when she is getting up. This is being tracked. This resident has recently being reviewed again by her Consultant due to a change in seizure activity.

During a family meeting on the 29/04/2015 all restrictions were discussed and management of restrictions were explained to the resident's representatives.

A meeting has been requested by the Person-in-Charge with the Occupational Therapy Manager plus the HSE primary care Occupational Therapist to review all mechanical and environmental restrictions in the D.C. including the use of bedrails.

Night Observation Recording Sheets are in place for tracking the requirement of bedrails for two residents who utilise them. Individual Night Checks are in place the frequency of which is based on the needs of the residents. These observation sheets are reviewed at the weekly staff meeting.

A protocol for the use of bedrails, if appropriate to continue usage, for the two residents will be put in place once the multidisciplinary review has taken place using the evidence provided by the night tracking.

**Proposed Timescale:** 01/09/2015

**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:**
Staff were administering crushed medications in the absence of instruction for this practice.

**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:**
The G.P. signed the Kardex and prescription for the use of crushed medication for one Resident on the 30/04/2015
The Supervisor met with the Pharmacist regarding using crushed medication on the 30/04/2015 and a protocol was put in place.

**Proposed Timescale:** 30/04/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider had not ensured that staffing levels were based on the assessed needs of residents.

**Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
The staffing in the D.C. has been reviewed taking into consideration National Agreements on staffing to include roster changes to ensure the efficient use of the allocated complement. The roster has been re-arranged to provide four staff on five days of the week to facilitate resident's daily activities.

Student social care workers are also gaining work experience in the D.C. and are assisting with providing activities on the two days when only three staff are allocated.

The Supervisor works frontline if a staff member is absent, e.g. due to training or sick leave, in order to facilitate Meaningful Day activities for Residents.

Day and evening activities have improved significantly for Residents with the Supervisor reporting on three occasions during the last month that the house was empty due to all six residents being out on activities.

**Proposed Timescale:** 01/05/2015