<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St John of God Community Services Limited</th>
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<td>Centre ID:</td>
<td>OSV-0002934</td>
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<tr>
<td>Provider Nominee:</td>
<td>Sharon Balmaine</td>
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<tr>
<td>Lead inspector:</td>
<td>Conor Brady</td>
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<td>Support inspector(s):</td>
<td>Conor Dennehy; Sheila Doyle</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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 2 day(s).

The inspection took place over the following dates and times

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


Summary of findings from this inspection

The provider is St. John of Gods Community Services Limited (hereafter called the provider) which is a company registered as a charity. This was an unannounced inspection of a designated centre located on a large campus based setting owned by this provider. 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 inspectors met with the person in charge, clinical nurse manager (CNM), nursing staff, care staff, community employment staff and residents. The inspectors observed practice and reviewed documentation such as personal care plans, healthcare plans, medical/clinical information, accident and incident records, risk assessments, medication records, meeting minutes, policies, procedures and protocols, governance and management documentation, staff training records and staff files. Thirteen residents resided in this designated centre which was an old premises located on a campus based setting. The centre comprised of three chalet style bungalow buildings. One building accommodated eight residents, one building accommodated four residents and one chalet was segregated into two apartments one of which accommodated one resident.
The inspectors observed institutionalised practices taking place in this designated centre that were having a direct negative impact on resident's opportunities to enjoy a good quality of life. For example, residents were not being supported sufficiently to participate in meaningful activities and residents personal plans were found to be out of date and not reviewed and updated in line with residents needs. Inspectors were concerned that there was a lack of appropriate governance and management in this centre in terms of ensuring all residents care needs were appropriately assessed and implemented by staff. Inspectors found that staff in this centre were not operating (at all times) in line with their own organisational policies. For example, in the areas of the provision of personal intimate care, safeguarding and safety and health, safety and risk management.

Overall the inspectors found that there was substantial non compliance in all of the areas inspected against within this designated centre. The inspectors found significant non compliance with the requirements of the Regulations and Standards. All of these areas are discussed in more detail in the main body of the report and in the action plan outlining the failings identified that did not meet the requirements of the Regulations and Standards.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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:

Overall the inspectors did not find that all residents' had meaningful opportunities to partake in activities appropriate to their assessed needs, interests and/or preferences. While inspectors found that residents had individualised assessments in place these did not adequately reflect residents' social care needs and were not appropriately reviewed or implemented. The inspectors found that resident's personal plans required significant further improvement to meet the requirement of the Regulations. Inspectors found that there was a disconnect between residents personal plans and the actual care being delivered in this centre.

The inspectors found the personal plans in this centre to be of a poor standard. Inspectors noted resident's goals, ambitions and preferences were not person centred and did not reflect residents needs, interests or preferences. Inspectors found very basic social goal setting for residents such as 'I would like to see the doctor when I am sick’ as an annual goal for a resident, as opposed to appropriate goal setting to meet residents social care needs. Inspectors found personal plans to be out of date with some plans not having appropriate evidence of review since 2013. Other plans were clearly marked for review and inspectors found that these reviews did not take place. When discussed with staff, inspectors were informed that reviews did not take place due to staff changes/shortages. The inspectors found that there was an absence of a review of effectiveness of resident's personal plans. For example, inspectors found a lack of appropriate oversight in terms of the effective monitoring of resident's goals, person centred plans and the implementation and review of personal plans in general. Inspectors found that consultation with residents' regarding planning was not appropriately recorded and that residents’ personal plans were not available in accessible formats for residents.
From discussions with staff, residents and on reviewing residents' care plans, progress notes and personal outcome measures, it was clear to the inspectors that the meeting of residents social care needs was resource led. While inspectors found some residents had opportunities to attend a day services, other residents who remained in the designated centre all day were found not to be provided with opportunities for meaningful activities. For example, inspectors noted the allocation of 2 hours per week for 2 residents for social activation. Inspectors found evidence that this minimal allocation was not being implemented. For example, the staff members responsible for this activation did not report to duty to complete this programme on the inspection date. Inspectors were informed by the staff who were present that they did not know where these staff were. Staff informed inspectors that these staff would sometimes 'be pulled' due to staff shortages. This meant that two residents received no social activation on these occasions.

The inspectors found that residents had very limited opportunities to engage in social activities outside of their day service, the designated centre and external to the provider's campus. From reviewing residents care-plans, progress notes and based on inspectors observations and discussions with staff, it was evident that the priority in the centre was meeting residents basic needs and as a result social care needs were not being promoted.

**Judgment:**
Non Compliant - Major

**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 inspectors found that improvements were required in this area to ensure the health and safety of residents, visitors and staff was appropriately promoted and that systems were in line with the Regulations and Standards.

Inspectors found that while there were risk management policies and procedures in place these were not being fully implemented at local level. For example, inspectors were informed that all policies were available but staff did not always have time to read them. Inspectors found that this resulted in some cases whereby staff were providing care for residents without being sufficiently familiar with the appropriate policy and in some cases the residents care plans. For example, the provision of personal and intimate care.
In addition, while inspectors saw some evidence of risks being assessed there was not an appropriate correlation between the incidents and accidents log and risk assessments within the designated centre. For example, residents who were at risk of falls (based on incidents of same) not having appropriate and up to date care planning and risk assessment regarding same. Inspectors found that one resident who displayed behaviours of concern in this designated centre and was subject of considerable multi-disciplinary input was assessed as requiring substantial staff support and physical restraint for routine personal care. The inspectors found that while very specific risk management protocols were in place in this regard they were not always being adhered to. This will be discussed further under Outcome 8 - Safeguarding and Safety. In addition, inspectors found that there was not always enough staff for this intervention to be completed as prescribed. For example, inspectors found instances whereby the resident was not supported with his personal care at night due to lack of available staff. This will be discussed further under Outcome 17 - Workforce

Inspectors found measures in place to prevent infection in this centre appeared adequate. Staff were observed using anti-bacterial hand wash on a regular basis.

Inspectors noted there were not adequate precautions to prevent against the risk of fire within the designated centre. External maintenance checks of the fire alarm system had been carried out quarterly and fire fighting equipment had been serviced twice a year. However it was noted that a number of internal staff checks of fire equipment, such as emergency lighting, had not been carried out as required by the centre’s own Fire Safety Register dated January 2015. During the course of inspection it was observed in all three units of the centre that the lighting on some emergency exit signs were not working. Fire drills were carried out within the designated centre and personal evacuation plans were in place for residents. However these plans were not sufficiently detailed or updated to guide practice. For example there was no evidence that one resident who lived on his own in a self contained apartment had ever participated in a fire drill. Correspondence seen by inspectors between staff involved with this resident indicated that some additional supports were needed for this resident to counter the risks from fire. However the resident’s personal evacuation plan did not appropriately reflect this. Inspectors reviewed a sample of staff files. From these files it was noted that all staff working in the centre had not undergone fire safety training and use of fire safety equipment.

Overall inspectors were not satisfied that risk assessments were assessed, implemented and reviewed appropriately to ensure all risks in the centre were appropriately mitigated and/or managed.

**Judgment:**
Non Compliant - Major
Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

Findings:
Inspectors found substantial improvements were required to ensure adequate measures were in place to protect all residents from abuse and promote a safe environment.

Inspectors found a policy in place regarding the safeguarding of vulnerable adults (2013). The inspectors found a system in place whereby there was a designated liaison person and protocol for reporting allegations. The inspectors reviewed a number of instances whereby this process was followed. The inspectors found that while some staff had received training in this area all staff were not trained and/or familiar with the policy and protocols for reporting abuse. For example, in reviewing all staff training records inspectors found all staff in this centre did not have safeguarding training completed. In addition, inspectors found that all staff were not familiar with the reporting mechanisms for reporting confirmed, alleged or suspected abuse of residents.

The inspectors were concerned that some staff were completing personal/intimate care with residents without having read resident's care plans in some cases. Inspectors spoke to staff who had not read intimate care plans but were supporting residents with intimate care.

The inspectors were very concerned to read in the incidents and accidents log of a recent instance whereby a resident was found in a state of incontinence and was not changed/supported with personal care 'due to staff shortages'. This concern was clearly defined to the provider and person in charge as an omission of this resident's basic physical care needs and therefore met the criteria of neglect. The inspectors therefore sought and were given assurance from the person in charge that these issues would be immediately examined by management to ensure all residents were safe and that their basic personal care needs were being met at all times.

Inspectors found that safeguarding measures were not being followed at local level and found an instance whereby injuries/marks were observed to a resident but protocols had not been followed. For example, no body mark charts or reporting documentation had been recorded or reported regarding marks found on a resident the morning of the second day of inspection. Inspectors highlighted this to the CNM on duty who indicated that protocol had not been followed 'by night staff'. Inspectors instructed she follow this
matter up appropriately with immediate effect. Inspectors reiterated this concern to the person in charge to follow up on same to ensure this matter was appropriately investigated. The local implementation of safeguarding and safety practices within the centre were not enacted in this case consistently and in line with organisational policy. Inspectors found that the communication between day and night staff had omitted to address this safeguarding issue.

Inspectors found that practices within the centre were institutional and left residents vulnerable as a result. For example, residents were being treated collectively rather than as individuals in terms of their basic care/personal care needs. There were set times for dining/provision of food and rigid routines for leaving the designated centre to go to day services. Inspectors observed practice to be resource led in all of these areas. Inspectors were concerned that this institutional approach to practice coupled with the lack of staff supervision and management, lack of appropriate training and poor record keeping, meant that residents were vulnerable in this designated centre.

The inspectors found evidence of multidisciplinary review and behavioural support planning taking place. The inspectors found evidence of intensive multidisciplinary support regarding one resident with complex behavioural needs. However, as outlined in the previous outcome the inspectors were concerned that the prescribed protocols for one resident requiring substantive support (including the use of physical restraint) regarding his personal and intimate care, were not being followed at all times. For example, inspectors noted a lack of staff availability to complete this task, a lack of trained staff involved in this intervention (on occasions), and a lack of a consistent implementation of this plan. As a result there was a potential for inconsistent care and negative outcomes for this individual.

Judgment:
Non Compliant - Major

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:
Although inspectors found some examples of good practice, from the documentation reviewed, they were not satisfied that residents were supported to achieve and enjoy the best possible health. In addition, staff spoken with were very unclear as to where particular documents were stored, reviewed or how they could be accessed. Inspectors were concerned that this could seriously impact on the delivery of care to the residents.
Inspectors reviewed the management of nutrition. Although some care plans recommended that residents were weighed on a monthly basis this was consistently carried out. In one case reviewed, inspectors saw that a resident, who was to be weighed on a monthly basis, had not been weighed for five months. Staff spoken with said they did not always have the time to take the weights and that specialised weighing scales were not available and had to be borrowed from another centre.

Inspectors were also concerned that some residents appeared to be waiting for review by a dietician for over six months. Staff were unclear if the reviews had happened and inspectors could not find documented evidence. Similar delays were noted as regards access to the speech and language therapist and psychology services. Staff were unsure if the reviews had taken place. For example, inspectors saw that a resident had been referred to the psychologist six months previously. No evidence was available to inspectors to ascertain if this review had occurred and staff spoken with were not aware of same.

Inspectors reviewed the care of a urinary catheter. Again it was difficult to locate the relevant documents. There was a page outlining general care to be carried out including daily cleaning of the site. However there was no documented evidence if this occurred. In addition for this resident, the intake and output chart was incorrectly filled in while for another resident although the care plan stated that an intake and output chart was to be recorded, this was not in place at all.

Inspectors were also concerned regarding the lack of documentation of care relating to pressure area management. Inspectors were told that a particular resident was turned frequently whilst in bed and a specialised mattress was in use. However inspectors could not find any care plan relating to this. Some recommendations by various allied health professional were in place. Inspectors saw that the occupational therapist had recommended frequent posture changes. Inspectors could not find evidence to support this. For one resident, returning from the day services, it was noted that the last recorded procedure was four hours earlier.

Inspectors reviewed wound management procedures and saw that appropriate assessments and treatment plans were in place. Residents had access to the services of a tissue viability nurse if required.

Inspectors read where residents' end of life preferences were recorded including their preference regarding transfer to the general hospital should their condition deteriorate.

Residents had access to GP services and out of hours cover was provided. An annual health check was carried out including routine bloods, blood pressure recordings etc. Inspectors also saw that residents had access to other services such as optician and audiology services, either privately or publically.

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:
Inspectors were not satisfied that the centre had appropriate and suitable practices relating to the receipt, prescribing, storing and administration of medicines.

Inspectors reviewed a sample of prescription and administration records and noted that improvements were required. For example in some prescriptions it did not state how often a medication was to be administered. In addition, for medication to be administered as and when required (PRN), the maximum dose that could safely be administered in a 24 hour period was not consistently recorded.

Some residents required their medication to be crushed. Inspectors saw that that this was not individually prescribed as such, in line with professional guidelines. In addition, the policy did not provide sufficient guidance around this practice.

Action was also required around the checking of medications that required strict controls. Inspectors reviewed the system in place for the administration of these medications and saw that this was in line with best practice. Balances checked were correct. However inspectors noted that the end of shift checks were not consistently completed. In some cases several days had elapsed between these checks.

A secure fridge was provided for medications that required specific temperature control. Inspectors reviewed the temperature was within acceptable limits at the time of inspection. However inspectors saw that the required daily monitoring of the temperature was not consistently recorded. Several gaps were evident.

An audit had been completed in July 2014 and this had identified the need to make the system for receiving and checking medications from pharmacy more robust. This including getting two people to check the supplies against the orders and prescriptions and assigning a person responsibility to ensure these checks were complete. A repeat audit was carried out in December 2014 and the centre was found to be compliant. However inspectors could not find any documented evidence that this was now happening. Staff spoken with said they no longer documented this.

Inspectors also read the medication policy and found that it did not provide sufficient guidance to staff in some areas. Action relating to this is included under Outcome 18.
Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors were very concerned at the lack of governance and oversight by the provider and persons participating in the management of this centre as evidenced by the high number of non compliances. This lack of compliance does not demonstrate that the provider has engaged in the regulatory process since commencement. Inspectors found deficits in the provision of safe care, safeguarding, quality of life and healthcare for residents. The failure of the provider to review and engage in oversight of the service provided to residents has resulted in negative outcomes for these residents.

The person in charge was not adequately involved in the effective governance, operational management and administration of the designated centre. The person in charge held a Director of Nursing position based on the campus and was nominated person in charge for 8 designated centres overseeing the care of 147 residents across all of these centres. The person in charge informed the inspectors at the outset of inspection that this decision was currently being reviewed by the provider and restructuring was planned. The inspector was shown a number of correspondences written by the person in charge to senior management in the organisation highlighting her inability to carry out her role as person in charge due to resource issues highlighting staffing levels as 'un-safe' at times.

The inspectors found that the person in charge did not work in the designated centre, did not regularly visit the designated centre and did not attend staff meetings in the designated centre. The inspectors found that the person in charge was not a presence in the designated centre and managed the centre through monthly meetings with the clinical nurse manager. There was not sufficient monitoring and management practices evident in this centre. Inspectors found that the person in charge was not adequately involved in governance, management and oversight in the designated centre in terms of ensuring the centre was in compliance with the Regulations and Standards.

Aside from the person in charge the inspectors found the centre was managed by a
Clinical Nurse Manager (CNM) and was supported by staff nurses, care assistants, a community employment scheme worker and domestic staff. While this offered some structure the inspectors did not find clear lines of authority and accountability. For example, as evidenced in the findings of all outcomes inspected, the inspectors found a lack of appropriate accountability and professional responsibility regarding regulatory compliance in the centre. For example, in the areas of:

- Social Care Needs
- Health, Safety and Risk Management
- Safeguarding and Safety
- Healthcare Needs
- Medication Management
- Records and Documentation

When inspectors sought specific information from the person in charge they were told to request same from the CNM. The CNM in turn could not provide this information to inspectors. For example, evidence of auditing of care plans, auditing of local protocols, evidence of performance appraisal with staff, audit of staff training, six monthly/annual review of care delivery in the centre. The CNM highlighted resources as a significant problem. Inspectors found there was not sufficient oversight to ensure the safe delivery and quality of care to residents in this centre. Inspectors were not satisfied that this designated centre was being managed appropriately in accordance with the requirements of the Regulations and Standards.

Judgment:
Non Compliant - Major

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:
Overall inspectors found that substantive improvement was required regarding the staff number and skill mix in this centre. Furthermore inspectors found that there were gaps in mandatory and required centre specific training in reviewing staff files and training schedules.
Inspectors found that staff numbers and skill mix did not meet the needs of the residents. Inspectors found that the provision of care was resource led with the majority of residents movements and routines revolving around staff availability. For example, inspectors noted a number of residents who had epilepsy seizure activity who had been sent to day services because staff in the centre had to perform personal care with other residents and could not supervise them.

A resident without a day service was observed walking around the centre with little engagement with staff in the absence of his activation staff (as per his care plan) being present on the inspection date. As highlighted earlier in the report, staff members who were due to work with this resident did not show up for duty. Inspectors found that there was a local protocol of 'borrowing staff' from other centres (on the providers campus) at night time which was not suitable according to the CNM. This practice was being used to assist in the provision of personal care for a resident requiring significant support. Inspectors were informed and noted from documentation reviewed that these staff were often unknown to the resident and untrained in his very specific behavioural management plan. Inspectors were concerned that whereby a resident was assessed (following substantive multidisciplinary review) as requiring a certain number of staff, this number of staff was not always available to this resident, when required. To supplement this deficit the designated centre was 'borrowing' staff from another centre who were not trained or known to the resident.

Inspectors found that agency staff were not reflected on the staffing roster which did not make it clear who was on duty in the centre on a given date. Inspectors reviewed a sample of files for staff working in the centre. While these files contained most of the records required by the Regulations it was noted that two such files did not have forms of identification with recent photographs of staff. Furthermore it was observed that all staff were not fully recorded as having up to date training in manual handling, fire safety, safeguarding and safety, epilepsy management, crisis prevention intervention and physical intervention training. In addition, inspectors found that neither the person in charge nor the CNM had conducted any supervision or performance management appraisals with staff since 2013.

**Judgment:**
Non Compliant - Major
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:
This outcome was not inspected against. Action relating to the medication policy is included here.

Inspectors read the medication policy and found that it did not provide sufficient guidance to staff in some prescribing, administering and checking practices. In addition, inspectors found that all Schedule 5 policies were not being implemented. For example, risk management and provision of intimate care policies.

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:

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

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<tr>
<td>Date of Inspection:</td>
<td>25 March 2015</td>
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<td>Date of response:</td>
<td>04 June 2015</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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:
Personal plans were not appropriately developed and updated to reflect the assessed needs of residents.

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive

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

1. ‘My Personal Plan’ (MPP) template will be reviewed.

2. All MPPs will be updated to reflect the assessed needs of residents. This plan will be reviewed on an annual basis.

3. To further support the resident’s comprehensive assessment all staff will be scheduled to receive training in the role of keyworker, meaningful day and goal setting, intimate care, safety and risk management in line with Kildare Service Training Plan.

**Proposed Timescale:**

1. 30/06/2015
2. 31/12/2015
3. 30/09/2015

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<td>Effective Services</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Plans were not accessible to residents.

**Action Required:**

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

1. An accessible easy read MPP will be developed in consultation with Speech & Language Therapy department.

2. A schedule will be developed for keyworker’s/co-keyworkers to complete the accessible MPP with all residents and/or their representatives.

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Plans were found not to be reviewed.
**Action Required:**
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

**Please state the actions you have taken or are planning to take:**
1. An audit of MPP reviews will be conducted.

2. Following the initial review of the MPPs as above (1), an annual review schedule will be developed and implemented.

**Proposed Timescale:**
1. 31/08/2015
2. 30/06/2016

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**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:**
Plans did not reflect maximum participation of residents.

**Action Required:**
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

**Please state the actions you have taken or are planning to take:**
Residents and their representatives will be invited to actively participate in the development and review of their MPP; they will be supported to participate in meetings. Evidence of residents and their representative's involvement in their MPP will be documented in the MPP.

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**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:**
The designated centre was not meeting the assessed needs of all residents.

**Action Required:**
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.
Please state the actions you have taken or are planning to take:  
1. A review of all available data will be undertaken to ensure all residents accessed needs are identified. 

2. The Person in Charge (PIC) will meet with the Clinical Nurse Manager (CNM) and the team on a fortnightly basis for regular reviews and updates on progress relating to residents accessed needs. 

3. Staff rosters are under review to ensure consistency and effective utilisation of the current resources in the DC to meet the assessed social care needs of residents. 

Proposed Timescale:

1. 04/08/2015  
2. 08/06/2015  
3. 31/10/2015

Proposed Timescale: 31/10/2015 

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect: 
There were not adequate arrangements in place to meet residents assessed needs.

Action Required: 
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident. 

Please state the actions you have taken or are planning to take: 
1. A review of all available data will be undertaken to ensure all residents accessed needs are identified. 

2. The PIC will meet with the CNM and the team on a fortnightly basis for regular reviews and updates on progress relating to personal plans. 

3. Staff rosters are under review to ensure consistency and effective utilisation of the current resources in the DC to meet the assessed social care needs of residents. 

Proposed Timescale:

1. 04/08/2015  
2. 08/06/2015  
3. 31/10/2015

Proposed Timescale: 31/10/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy not fully implemented. Adequate system for the assessment and on-going review of risk was not sufficiently understood or implemented at local level.

Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
1. All staff will read and sign that they have understood the Risk Management Policy and Site Specific Emergency Plan.
2. All staff will receive risk training as per Kildare Services Training Calendar for 2015.
3. All incidents/accidents and risk assessment reviews will be reviewed at the fortnightly staff meeting and corrective action/learning will be communicated to all staff.

Proposed Timescale:
1. 30/06/2015
2. 31/08/2015
3. 08/06/2015

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All equipment was not functioning.

Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
1. The fire register has been checked and will be updated.
2. Ensure all staff complete fire safety training including the use of fire extinguishers.

Proposed Timescale:
<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>08/06/2015</td>
<td>1. Ensure all staff complete fire safety training including the use of fire extinguishers.</td>
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<tr>
<td></td>
<td>2. Ensure all required daily fire checks are completed twice daily.</td>
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<td></td>
<td>3. Review all residents individual Personal Emergency Evacuation Plans (PEEPs).</td>
</tr>
<tr>
<td>08/06/2015</td>
<td>1. All PEEPs will be reviewed and updated as required.</td>
</tr>
<tr>
<td>30/09/2015</td>
<td>2. A deep sleep drill will be conducted.</td>
</tr>
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</table>

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Evacuation procedures and protocols required improvement.

**Action Required:**

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

1. All PEEPs will be reviewed and updated as required.

2. A deep sleep drill will be conducted.

**Proposed Timescale:**
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff were not in receipt of up to date training in fire.

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

**Please state the actions you have taken or are planning to take:**
1. Fire safety training will be scheduled for all staff as required.
2. Ensure all staff participate in a planned fire drill.

**Proposed Timescale:**
1. 30/09/2015
2. 31/12/2015

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence of drills and evacuation procedures in all parts of the centre.

**Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
1. Quarterly fire drills will continue to take place in the DC.
2. The PIC will identify dates where each staff and resident has taken part in a planned fire drill to ensure effectiveness of PEEPs.
Proposed Timescale:
1. 31/07/2015
2. 31/12/2015

### 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:**
All staff performing and involved in behavioural management interventions/techniques were not appropriately trained in these interventions.

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

**Please state the actions you have taken or are planning to take:**
A schedule of training will be developed for staff that require training in management of actual potential physical aggression (MAPA).

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**Proposed Timescale:** 10/07/2015

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All residents were not being adequately protected by the effective implementation and governance of organisational and national policy in this designated centre regarding the prevention, detection and response to abuse inclusive of neglect and acts of omission.

**Action Required:**
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
1. All staff will read and sign that they have understood the Safeguarding Vulnerable Adults Policy.
2. All staff will read and sign that they have understood the policy on Personal Intimate care.
3. All intimate care plans will be reviewed.
Proposed Timescale:
1. 12/06/2015
2. 12/06/2015
3. 31/08/2015

Proposed Timescale: 31/08/2015
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not appropriate investigation or follow up whereby a resident was found to have marks on their body.

Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
1. A schedule of training will be developed and completed for staff who have not received training in Safeguarding Vulnerable Adults.
2. A record of screening outcomes of safeguarding incidents will be advised to the PIC.
3. Local Risk Management policy and action plan (section 7) will be reviewed in terms of ensuring listed precautions are in place and are evidenced.

Proposed Timescale:
1. 30/09/2015
2. 30/06/2015
3. 31/08/2015

Proposed Timescale: 30/09/2015
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff performing intimate care were not familiar with personal plans.

Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such
assistance do so in line with the resident’s personal plan and in a manner that respects the resident’s dignity and bodily integrity.

**Please state the actions you have taken or are planning to take:**
1. All staff will read and sign that they have understood the policy on Personal Intimate care.

2. All Intimate care plans will be reviewed and to be updated.

3. A local operational procedure on privacy and dignity will be developed

Proposed Timescale:

1. 12/06/2015
2. 31/08/2015
3. 31/08/2015

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

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff did not demonstrate appropriate knowledge of safeguarding vulnerable adults.

**Action Required:**
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**
1. All staff will read and sign that they have understood the Safeguarding Vulnerable Adults Policy.

2. All incidents of a safeguarding nature will be reported to the Designated Liaison Safeguarding Person.

Proposed Timescale:

1. 12/06/2015
2. 29/05/2015

**Proposed Timescale:** 12/06/2015
### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
- It was unclear if reviews by health professionals were carried out in a timely manner. The care plan documentation was not specific enough to guide practice.
- Routine assessments such as weight measurements were not consistently carried out.
- There was inadequate records of the care provided or otherwise.
- Listed interventions were not consistently carried out.

**Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident’s personal plan.

**Please state the actions you have taken or are planning to take:**
1. Residents healthcare assessments (skin care, catheter care, weight monitoring, food and nutrition) will be reviewed to ensure all recommendations are implemented and communicated to all staff.
2. The annual health assessments will identify assessed need and a process of referral will follow.
3. Reviews by allied healthcare professionals will be requested to be carried out and the request recorded in the residents MPP. All new recommendations will be communicated to all staff.

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

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### Outcome 12. Medication Management

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
- There were some inappropriate practices relating to the receipt, prescribing, storing and checking of medicines.

**Action Required:**
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
1. All staff with responsibility for medication administration will be reinducted into the organisational policy on Medication Management and procedures re monitoring of fridge temperature, checking of controlled medications and crushed medication will be
implemented.

2. Medication administration record sheet (MARS) will be introduced to the DC.

3. Medication reconciliation will be completed by the pharmacist prior to implementation of the new MARS.

4. Identified discrepancies will be reconciled between the pharmacist and GP practice.

5. A medication audit will be conducted.

Proposed Timescale:
1. 15/07/2015
2. 13/07/2015
3. 12/06/2015
4. 11/06/2015
5. 07/10/2015

**Proposed Timescale:** 07/10/2015

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**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge was not ensuring the effective governance, operational management and administration of the designated centres concerned.

**Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
1. The role of the PIC is under review.
2. An interim PIC arrangement is now in place for the DC.
3. A successful recruitment drive has been undertaken to recruit a permanent coordinator who will assume the role of PIC for this DC. The PIC will be actively involved in the governance and management of the DC.

Proposed Timescale:
1. 30/06/2015
2. 11/05/2015
### Proposed Timescale: 31/07/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was not clear lines of accountability and responsibility evident.

**Action Required:**
Under Regulation 23 (1) (b) you are required to:
- Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
1. A Review will be completed regarding the governance and management in the DC that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of DC.
2. The Statement of Purpose (SOP) will be reviewed in line with new governance management structures.
3. A service organogram will be distributed to all staff highlighting the new structure.

**Proposed Timescale:**
1. 31/07/2015  
2. 30/06/2015  
3. 31/07/2015

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### Proposed Timescale: 31/07/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Ineffective management systems were found in this centre.

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

**Please state the actions you have taken or are planning to take:**
1. A review of the local organisational governance structure is currently underway.
2. The Provider Nominee chairs the weekly Strategic Management Team meeting.

3. A PIC Implementation Weekly Team Meeting has been established.

4. DC Staff Meetings have been established.

5. All staff will be advised of lines of management, reporting systems, roles responsibility and accountability when completed.

6. The Quality & Safety committee review all data and other relevant reports.

7. Multidisciplinary team (MDT) reviews will continue to take place as necessary.

Proposed Timescale:

1. 31/07/2015
2. 30/04/2015
3. 07/05/2015
4. 31/05/2015
5. 31/07/2015
6. 19/05/2015
7. 19/05/2015

**Proposed Timescale:** 31/07/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
No evidence of annual review having taken place.

**Action Required:**
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

**Please state the actions you have taken or are planning to take:**
1. The Quality & Safety committee will review all audits, data and other relevant reports i.e. unannounced visits to ensure action plans are developed and recommendations are followed up and monitored by the PIC.

2. An annual review of the quality and safety will be completed

Proposed Timescale:

1. 31/07/2015
2. 31/01/2016
Proposed Timescale: 31/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No evidence of unannounced visits taking place and appropriate monitoring of safety and quality of care and support provided in the centre.

Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
Findings from previous audits and action plans will be included in the DC Quality Enhancement Plan and actioned.

Proposed Timescale: 31/07/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff numbers and skill mix was not meeting 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:
1. Staff rosters will be reviewed.

2. Allocation of staff is being reviewed.

Proposed Timescale:
1. 04/08/2015
2. 31/10/2015
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<thead>
<tr>
<th>Proposed Timescale: 31/10/2015</th>
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<tr>
<td><strong>Theme:</strong> Responsive Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff were not present on the staff roster with agency staff unnamed on the roster making it unclear for staff and residents who was actually on duty on a given date.

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

**Please state the actions you have taken or are planning to take:**
An actual staff roster for all agency staff showing staff on duty at any time during the day and night will be attached to staff roster.

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<thead>
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<th>Proposed Timescale: 08/06/2015</th>
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<td><strong>Theme:</strong> Responsive Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff training in mandatory and centre specific training was not up to date or in place.

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

**Please state the actions you have taken or are planning to take:**
1. A schedule of training will be developed to address any identified gaps in mandatory and centre specific training and will include training in Epilepsy, Fire, Manual Handling, MAPA and Safe Guarding Vulnerable Adults.

2. The PIC will review the status of all staff training records in the DC.

<table>
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<tr>
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<tbody>
<tr>
<td><strong>Theme:</strong> Responsive Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not being appropriately supervised in their role.

**Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
1. The PIC will review staff supervision in the DC. A local operational procedure on staff supervision will be developed.

2. Performance development reviews (PDRs) will be completed with all staff and evidenced in their Human Resource (HR) file. Additional staff support meetings will be arranged as necessary.

3. The CNM will attend fortnightly meetings with the PIC and Programme Manager.

**Proposed Timescale:**

1. 31/07/2015
2. 31/12/2015
3. 04/06/2015

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

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect: Schedule 5 policies not implemented.

**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:**
All staff will sign they have read and understand all policies and procedures set out in Schedule 5 of the Regulations (2013) with priority given to Safeguarding Vulnerable Adults, Risk Management and Safety, Medication Management, Personal Plans and Fire.

**Proposed Timescale:** 12/06/2015

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect: The medication policy found did not provide sufficient guidance in procedures.
**Action Required:**
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**
The medication policy will be reviewed in order to further guide practice in prescribing, administrating and checking practices.

**Proposed Timescale: 12/06/2015**