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-0003025
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Bernadette Shevlin
Lead inspector:	Jillian Connolly
Support inspector(s):	Philip Daughen
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
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:
18 February 2015 10:00	18 February 2015 18:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The designated centre is the home of twelve residents and is located in a campus setting, alongside numerous other centres which are operated by the one provider. A re- configuration had occurred of the number of designated centres within the campus, since the centre was last inspected in May 2014. This was the first inspection of the designated centre since that had occurred.

In October 2014, the Chief Inspector issued a warning letter to the registered provider in respect of all designated centres within the campus. This pertained to inadequate staffing levels. Staffing levels were found to remain inadequate and therefore affect the safe and effective services provided to residents.

Ten outcomes were inspected. There were five moderate non - compliances identified, in respect of the privacy and dignity of residents, the social care needs of residents, the health care needs of residents, notifications to the Chief Inspector and Incomplete documentation. Five major non - compliances were found in the following outcomes:

- Safe and Suitable Premises
- Health and Safety and Risk Management

- Safeguarding and Safety
- Governance and Management
- Workforce

There were twenty five failings with regulations identified. Fifteen of which are the responsibility of the provider and ten of which are the responsibility of the person in charge.

The action plan at the end of this report identifies the failings and the actions the provider/person in charge is required to take 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.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors observed staff to engage with residents in a dignified and respectful manner. Staff spoken to informed inspectors of the training that had been received following on from the last inspection to ensure that language utilised was appropriate to the residents and reflective of a home environment. However inspectors observed that improvements were still required to ensure that practices and the environment promoted and maintained the dignity of residents and that their right to privacy was ensured. As stated in Outcome 6, inspectors reviewed the premises and found that due to the size of bedrooms, residents' privacy was unable to be maintained. Staff demonstrated to inspectors the actions required to support a resident, who required the support of two staff and a hoist, to get in and out of bed. As there was insufficient space in bedrooms, once a resident was being supported by the hoist, the hoist needed to be wheeled out into the communal corridor to transfer the resident into their chair. Ten of the twelve residents required the support of two staff. Of the twelve rooms, inspectors observed six rooms that based on the needs of the resident, the equipment required and the size of the room, the privacy and dignity of residents was significantly compromised.

Inspectors also found that there were deficits in the storage of personal information of residents as documentation which recorded the fluid intake and urine output of residents was located on kitchen worktops and readily available for any individual in the centre to access.

Due to the needs of residents, collective residents' meetings would not be a meaningful forum for consultation with residents regarding the operation of the designated centre. However inspectors observed in the absence of this forum, alternative options had not

been attempted to ensure that residents' rights were considered as required by Regulation 9 (2) (a) and Regulation 9 (2) (b). There was an advocate available on a referral basis however this resource had not been utilised. There was also an insufficient amount of consultation with of residents and/or their representative regarding the operation of the designated centre as required by Regulation 9 (2) (e)

A deficit previously identified by inspectors in May 2014, was the absence of activities which were meaningful to residents and reflective of their choice and interests. On this inspection, improvements were identified in the provision of activities to residents. Inspectors reviewed a weekly schedule of activities which were available to all residents. There was also a daily list of activities for each resident which identified the activity to be offered in the morning and afternoon. This included activities such as walks, hand and foot massage and residents being read to. There had also been external resources obtained such as Gymboree and Dog Therapy. On the day of inspection, inspectors observed a sample of these activities in practice and found that residents were enjoying participating in same.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
As stated in Outcome 1, there had been an improvement in the opportunities residents had to access activities on a daily basis. Inspectors reviewed a sample of residents' personal plans and determined that whilst the activities offered had enhanced the quality of lives of residents there was still an absence of expectation and development of residents' skills. Inspectors found that personal plans did not inform of the supports required to maximise the personal development if residents as required by Regulation 5 (4) (b).

Residents had an assessment completed which identified the health care needs and the supports residents required for activities of daily living. There was also a communication

assessment in place for residents which included residents' likes and dislikes. Inspectors found that where a need was identified such as mobility, evidence based tools were utilised to assess the level of risk to residents. From these assessments, the system in place was that plans of care were developed. However, inspectors found that the presence and quality of these plans of care was inconsistent. As stated in Outcome 11, the care plans for residents' health care needs were, in the main informative, however the structure of some resulted in the information not being accessible and concise. For example, numerous residents had a diagnosis of osteoporosis however the supports residents required were embedded in the mobility care plans for residents. There was an absence of reference to this diagnosis in other pertinent plans of care such as eating and drinking. This was a risk, due to the regular absence of permanent staff supporting residents. This is discussed further in Outcome 17.

A further risk identified in the assessments and care plans was the absence of dates. Therefore it was unclear if the information had been reviewed to assess the effectiveness of the plan and amended to take into account a change in circumstances as required by Regulation 6 (5) (c) and (d). Inspectors found that some of the information was outdated, through speaking to staff and meeting residents. This presented a risk to residents receiving continuity of care due to the regular utilisation of unfamiliar staff.

Of the sample of files reviewed, there was inconsistency in the presence of goals or plans in place to meet the social care needs of residents. In some instances there were clear goals identified, which included the actions required to achieve these goals, and the person responsible for supporting the resident. There was also evidence that some of the goals had been achieved. For some residents there was an absence of goals or plans in place. Staff spoken to acknowledged this deficit and stated that this was due to inadequate staffing and supporting residents to sample different activities prior to plans being created.

There was evidence of the involvement of the multi disciplinary team for assessment and review in respect of health care needs.

There was an absence of evidence to support that consultation had occurred with residents and/or representatives regarding the personal plans of residents as required by Regulation 5 (4) (c).

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):
No actions were required from the previous inspection.

Findings:
The premises generally were in a good state of repair. However, the mobility of most of the residents was such that they required the assistance of a hoist to get in to and out of bed and required to use a wheelchair or comfort chair to move around the centre. The limited room size in these bedrooms meant that there was insufficient room for the residents to move from their bed to their chair. The chair had to be placed in the corridor outside and the resident moved in the hoist in and out of the bedroom. This represents an unsuitable arrangement and is not in the best interests of the convenience, privacy or dignity of the residents concerned, as stated in Outcome 1.

There were also areas both in the kitchen and in one of the bathrooms identified as requiring cleaning by inspectors while on inspection.

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):
No actions were required from the previous inspection.

Findings:
The fire alarm system in the centre was addressable. There was provision of emergency lighting within the premises. The centre was also provided with fire extinguishers throughout. All of the above appeared to be maintained in good working order although the records to demonstrate same were incomplete in some cases. One aspect of the fire management system was the requirement for staff to complete daily and weekly checks of equipment. Whilst the daily checks were consistently completed, the records for weekly checks such as fire doors were blank in places. All residents had personal

emergency evacuation plans which contained all relevant information for the residents.

Inspectors observed multiple cases within the centre of fire doors with no self closer, or fire doors that have had their self closer disabled or removed. The door fastenings were inconsistent with most final exits being fitted with thumb turns but one fitted with a fastening requiring the use of a key to escape. All internal doors were fitted with key locks although none appeared to be utilised. The door leaves and door frames were generally in good condition.

It was unclear from consulting documentation and signage/drawings within the centre if the evacuation procedure for the centre was phased or total evacuation. The limits of any sub compartments provided for phased evacuation were unclear from the documentation and drawings. The inspectors were not assured that the fire procedures were robust and fit for purpose. In the main, the exits from the premises were provided with external ramps and external lighting immediate to the final exit although the two bathroom exits had a step down which was not suitable given the evacuation methods (mainly wheelchair and comfort chair) identified in the evacuation plans for the residents.

The minimum staffing levels in the centre at night time was described to inspectors as one nurse and one assistant with one 'float' who may or may not be present or may be elsewhere within the wider campus. There was also a procedure for summoning assistance from other centres within the campus through the use of radios. Given the high mobility needs of the residents in the centre, inspectors were not assured that the staffing was sufficient to evacuate residents in the event of fire. Of the twelve residents, all were high dependency and they all required significant assistance from staff to evacuate. The prevalent evacuation method was by comfort chair and wheelchair. The lack of clarity in the procedure with respect to the extent of sub compartments meant it was unclear how many residents required evacuation immediately.

Records reviewed indicated that fire drills had been conducted but the records for same were sporadic with varying levels of detail. The fire drills did not record any instance where evacuation had reflected night time staff levels. The fire drill records did not demonstrate to inspectors that adequate arrangements were in place for the evacuation of the residents, particularly at night time.

In the generic fire procedure for the campus seen by inspectors, the shift leader for the centre was tasked with additional responsibilities for fire alarm activations in other buildings on the site due to the presence of a fire alarm repeater panel for the entire campus. This was confirmed by staff. These additional responsibilities were numerous but included meeting the fire service on arrival to direct them to the correct area on site. It was unclear in this procedure as to who would carry out these tasks in the event of a fire in the centre itself.

The centre had a risk management policy and risk register. The documentation was specific to centre but was overdue revision in accordance with the dates on the document. The risk register was noted as containing no detail as to the classification of the seriousness of individual risks or indeed any assessment of the effectiveness of any control measures implemented.

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):
No actions were required from the previous inspection.

Findings:
Inspectors identified through a desktop review of the notifications which were submitted to the Chief Inspector as required by regulation 31 (3) (d) that there had been numerous incidents of unexplained bruising being recorded by staff. There had been no investigation or preliminary screening conducted as required by the policy of the organisation for the protection of vulnerable adults for these incidents of unexplained bruising. Inspectors spoke with the person in charge regarding this during the course of the inspection, who stated that this was an area that they had identified since commencing their post in January 2015. Inspectors formally requested at the feedback meeting, that an internal investigation be conducted to ascertain the rationale for the deficits in policy being implemented in practice and for the registered provider to attain assurance that residents were safeguarded.

There were numerous residents who had a history of displaying behaviours that challenge. Inspectors found that there had been a significant reduction in the use of medication as required being prescribed as a reactive strategy in response to a resident being agitated or aggressive. However, record keeping did not consistently support this. For example, residents had antecedent screening tools in place which outlined the possible causes or rationale for a resident exhibiting challenging behaviour and the strategies that can be implemented to proactively prevent the same occurring. However, documentation was also present to support the use of medication as required, as a reactive strategy. Inspectors reviewed the prescription sheets of the resident and found that this medication was no longer prescribed to the resident. A risk was present as the personal plans had not been reviewed following this change. Staff were being guided by inaccurate information. Inspectors found that any restrictive practice utilised, including environmental and physical restraint had been discussed by the appropriate members of the multi disciplinary team and were reviewed regularly. Inspectors reviewed records regarding the use of physical restraint for a resident to be supported to undergo blood

tests. Inspectors confirmed that alternative options had been discussed by the multi - disciplinary team and that the benefit for the resident was greater than the risk of the physical restraint. However this had not been notified to the Chief Inspector as required by Regulation 31 (3) (a).

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
As stated in Outcome 8, inspectors found evidence that physical restraint had been utilised to support a resident to have blood tests. This had not been reported to the Chief Inspector as required by Regulation 31 (3) (a).

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
In the main, inspectors found that the health care needs of residents were being met. Residents had regular access to their general practitioner. Inspectors also confirmed that residents were referred to the appropriate Allied Health Professionals if a need was identified. There was appropriate assessments completed utilising evidence based tools to assess the level of risk to residents as a result of a need such as risk of falling or malnutrition.

As stated in Outcome 5, there were plans of care in place for identified needs such as epilepsy and diabetes. Inspectors found that these care plans were clear and measurable. There were also plans of care in place for food and nutrition and mobility. However the structure and layout of the care plans did not consistently identify the supports residents required to meet specific diagnosis such as osteoporosis or constipation. Inspectors determined that a risk was present as it was challenging to navigate through the documentation. Therefore unfamiliar staff would have to spend considerable time to ascertain the actual supports residents required. There was also an absence of cross referencing within the care plans. For example, if residents had a care plan for constipation, it referred specifically to prescribed medication. It did not outline the necessary information such as the proactive evidence based interventions which should be in place such as a high fibre diet. On review of the eating and drinking care plans the primary focus was if a resident required a modified diet as a result of dysphasia. There was no reference to their risk of constipation. This also resulted in an absence of evidence to support that the food provided to residents was appropriate to meet the specific needs of residents.

Inspectors observed the dining experience for residents and found that in the main it was a pleasant experience. Residents' meals were served to them utilising a table top on their personalised chairs as opposed to at the dining room table. Inspectors observed that residents were all in a circle facing each other to promote a social experience. Food was served to residents in a manner which promoted independence. However inspectors observed that there was insufficient staff available to support residents at this time. One staff member was responsible for five residents. This resulted in a delay in the time in which resident meals were served. The first two residents received their meal at 12.00 hours and the fourth resident received their meal at 12.20 hours. This was a considerable period of time for four residents to be served their meal. One of the five residents were receiving their nutritional needs via a Percutaneous endoscopic gastrostomy (PEG) feeding tubes. Also the one staff present was supporting a resident to eat and drink. They were not in a position to observe all residents. Therefore residents who did not want their meal were communicating same by holding up their plate. However this went unnoticed for approximately ten minutes. All residents were offered a choice at meal times.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge had been appointed to the position in January 2015. Inspectors met with the person in charge and determined that they had the appropriate knowledge of legislation and understanding of their statutory responsibilities. However the person in charge was employed in a wider management role for the entire campus. Therefore, although the person in charge is employed on a full time basis, there was no clear identification of protected hours within the designated centre. There was also an absence of frontline management due to absenteeism. Inspectors determined that this arrangement was insufficient. There was an absence of leadership within the centre and this was apparent through the deficits in documentation and the absence of staff supervision as identified within this report.

Whilst inspectors acknowledged that efforts were ongoing to achieve compliance with regulation, the cumulative findings of this report demonstrate there was a system in place to ensure that the service provided was safe, consistent and effectively monitored, specifically in relation to staffing.

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):

No actions were required from the previous inspection.

Findings:
The warning letter issued in October 2014 pertained to insufficient staffing. On the day of inspection there was seven staff on duty to provide direct care to residents. This staffing consisted of three staff nurses and four residential programme assistants. There was also a member of housekeeping staff on duty. Six of the seven staff was regular staff and one staff member was employed by an external agency. Inspectors were informed that the number of staff and skill mix can vary on a day to day basis. However, inspectors were informed that a full staffing compliment is considered eight staff from 08.00 hours to 18.30 hours and four to five staff from 18.30 hours to 20.00 hours. Staffing levels reduced to one staff nurse and one recreational programme assistant from 20.00 hours to 08.00hours. There were always two staff nurses on duty from 08.00 hours to 20.00 hours. The rationale for the change in staffing levels from a day to day basis was not clear. There was also no risk assessment completed of potential risk of reducing staffing levels at 20.00 hours by 75%.

From reviewing the assessments of residents and speaking to staff, inspectors determined that the majority of staff time was consumed with functional tasks such as supporting residents with activities of daily living. Ten of the twelve residents were assessed as requiring the support of two staff for continence support, getting up and going to bed and showering and bathing.

Inspectors determined that staffing levels were insufficient at night as a review of documentation supported that all residents require support in the night with continence. Therefore considering the dependency levels of residents and the layout of the building, staff are occupied for considerable periods of time and unavailable to respond to residents' individual and collective needs. This also applies for residents who wish to go to bed after 20.00 hours. As stated in Outcome 7, evidence did not support that the staffing levels were sufficient in the event of an emergency, based on the dependency levels of residents. As stated in Outcome 11, there was also insufficient staff available to support residents had mealtimes.

As stated in Outcome 14, there was no evidence that staff were appropriately supervised.

As previously stated whilst inspectors recognised that efforts were ongoing for compliance with regulation to be achieved. The cumulative findings and the major non - complinace identified, inspectors found that staffing levels were insufficient.

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):
No actions were required from the previous inspection.

Findings:
As stated in Outcome 7, the fire safety records were reviewed and it was found that the records relating to previous fire drills were sporadic with varying levels of detail. The fire safety maintenance records and daily, weekly fire safety checks carried out by staff were also incomplete.

As stated in Outcome 5, 8, and 11 records in respect of residents were not accurately maintained as required by regulation 21 (1).

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:

Jillian Connolly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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-0003025
Date of Inspection:	18 February 2015
Date of response:	02 April 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that residents were consulted regarding the running of the designated centre.

Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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

and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
1. Staff have been communicated with regarding the importance of ensuring residents are consulted with to ensure the appropriate running /organisation of the Designated Centre.

2. Staff will use a number of mediums to convey information including the utilisation of soft voice, pictures and communication styles suitable to residents understanding. Opportunities to increase use of sign language and object cues to be explored person by person, communication profiles to be developed accordingly. These skills will also prove beneficial for other forums including advocacy meetings

3. Terms of Reference have been developed to commence a residents committee at both a house level and designated centre level, where family/representative can attend. This will give residents and the family/representatives the opportunity to have their views heard and be involved in the decision making about day-today operations within the house and designated centre. The Person in Charge will notify residents and family/representatives of the scheduled dates and give everyone the opportunity to attend.

4. A resident's Advocacy Forum will be established with participation of family advocates as appropriate, which will provide another mechanism for consultation with residents and families/representatives.

Proposed Timescale: 31/05/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal Information of residents was located in an unsecured location.

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

Please state the actions you have taken or are planning to take:
1. Communication has taken place with staff to ensure the importance of maintaining confidentiality of residents in line with the data protection act and the Orders policy on confidentiality and dignity and respect.

2. As part of the induction process, confidentiality and data protection are discussed, which all staff are required to attend before commencing work in the Designated Centre.

3. In the absence of the Person in Charge, the manager or shift leader will continuously monitor confidentiality on a daily basis. The supporting template for manager/shift leader will be updated to reflect this.

Proposed Timescale: 30/03/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no forum in place to ensure that residents had the freedom to exercise choice regarding how they live their life.

Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
1. Terms of Reference have been developed to commence a residents committee at both a house level and Designated Centre level, where family/representative can attend. This will give residents and the family/representatives the opportunity to have their views heard and be involved in the decision making about day-today operations within the house and the freedom to exercise choice and control about their life.

2. A resident's Advocacy Forum will be established with participation of family advocates as appropriate, which will provide residents and families/representatives the opportunity to exercise choice and control.

3. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of resident's rights

Proposed Timescale: 31/05/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no forum for residents to participate in decisions regarding their care.

Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
1. Terms of Reference have been developed to commence a residents committee at

both a house level and Designated Centre level, where family/representative can attend. This will give residents and the family/representatives the opportunity to have their views heard and be involved in the decision making about day-today operations within the house and the freedom to exercise choice and control about their life.

2. A resident's Advocacy Forum will be established with participation of family advocates as appropriate, which will provide residents and families/representatives the opportunity to exercise choice and control.

3. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of resident's rights and the role of Key worker which supports residents from advocacy perspective.

Proposed Timescale: 31/05/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an absence of expectation and development of resident's skills within their personal plans.

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:
1. The Person in Charge shall commence a review of residents Individual Personal Plans (IPPs) within the designated centre to ensure care plans details the supports required to enable residents to develop their skills.

2. Support shall be provided to staff to develop programmes skills teaching etc. relevant to individual residents' needs. However many of these activities can be developed to take place in the home or within the local environment outside the home.

3. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of meaningful day and as a result staff in conjunction with the residents are completing the social assessments and identifying individual specific activities.

Proposed Timescale: 30/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was unclear if personal plans were reviewed to assess the effectiveness of the plans and to take into account changes in circumstances and new developments.

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:
1. The Person in Charge is currently undertaking a review of the Individual Personal Plans. As part of this review the Person in Charge will meet with the Clinical Nurse Manager to agree a structured schedule of when Individual Personal Plans are due for review. This will also include the process for evaluating care plans through auditing.

2. The Quality Team are conducting regular practice development sessions with staff, in regards to the importance of completing documentation adequately and reviewing care plans to ensure they reflect the residents needs, taking into account changes in circumstances and new developments.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Due to an absence of dates it was unclear if personal plans were reviewed annually.

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. The Person in Charge is currently undertaking a review of the Individual Personal Plans. As part of this review the Person in Charge will meet with the Clinical Nurse Manager to agree a flagging system for when the IPP is due for the annual multidisciplinary review.

2. The Quality Team are conducting regular practice development sessions with staff, in regards to the importance of completing documentation adequately and reviewing care plans to ensure they reflect the resident's needs, taking into account changes in circumstances and new developments.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not consistently support the social care needs of residents.

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:
1. Communication has taken place with the staff team within the Designated Centre to facilitate a holistic/social care approach when supporting residents and developing their care plans.

2. The Role of the keyworker is promoted at staff meetings and in all interactions with team members.

3. The Quality Team are conducting regular practice development sessions with staff on a 1-1 basis, in regards to the role and responsibilities of the keyworker. This will continue as part as an ongoing development programme.

Proposed Timescale: 31/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not evidence consultation with the resident and/or their representative.

Action Required:
Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, 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:
1. Staff shall document in the residents' Individual Personal Plans each of the consultations which takes place with the resident, in regards to the decisions made about their life.

2. Staff will use a number of mediums to convey information to residents including the utilisation of soft voice, pictures and communication styles suitable to residents understanding. Opportunities to increase use of sign language and object cues to be explored person by person, communication profiles to be developed accordingly.

3. Residents and where appropriate their families/representatives are invited to attend the annual multidisciplinary review of the resident Individual Programme Plam. This meeting provides the resident an opportunity to be involved in the decision making and consultation process in relation to their lives.

Proposed Timescale: 31/05/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Bedrooms did not facilitate residents privacy and dignity based on their size and 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:
1. When staff are supporting a resident with their personal needs in the bedroom, privacy screens shall be used, to ensure residents privacy and dignity is respected at all times.

2. The Person in Charge is currently exploring opportunities or potential alternatives rooms for residents, where the existing bedrooms are not facilitating the resident's privacy and dignity based on their size and the needs of residents. Where alternative options are not possible the Person in Charge will explore potential alternative care practices.

3. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of maintaining and protecting the resident's privacy and dignity

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Areas within the centre were not clean.

Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
1. Following the inspection, the areas which the inspectors identified as not being clean, were cleaned immediately.

2. Household staff have been communicated too, in regards to the importance of maintaining a clean house and ensuring the infection prevention and control standard operating procedure is adhered too.

3. The Director of Care and Support is currently in the process of identifying a consistent cleaning team, which will have clear cleaning schedule of work.

4. The Clinical Nurse Manager is responsible for validating the cleaning schedule on a daily basis.

5. The cleaning schedule will be monitored through the Manager/shift leader to ensure effective completion.

Proposed Timescale: 30/03/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risk management in the centre did not account for the actual risk hazards presented.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
1. The Person in Charge is currently working with the Risk Manager to ensure the Risk Management Policy is updated and reflects the actual risk hazards presented.

2. The updated revision on the Policy and Procedure will be communicated to all staff.

Proposed Timescale: 30/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the effectiveness of control measures.

Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
1. The Person in Charge is currently working with the Risk Manager to ensure the Risk Management Policy is updated and reflects the actual risk hazards presented and include the effusiveness of control measures.

2. The updated revision on the Policy and Procedure will be communicated to staff.

Proposed Timescale: 30/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were multiple fire doors in which the self closers were absent or disabled.

Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
1. The management of the service is currently up-dating their overall Fire Safety Plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit.

2. All staff have completed fire training and additional training site specific training including safe evacuation procedures , completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th, and 9th April 2015.

3. The Emergency Evacuation Plan has been reviewed and updated fore this Designated Centre and it's contained within the Fire Safety Register.

4. The Night time Evacuation Plan has been reviewed and updated for this Designated Centre.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire procedure specific to the centre was not clear :
- steps down from exits

- additional responsibility of staff with no contingency arrangemnets

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. The management of the service is currently up-dating their overall Fire Safety Plan in consultation with recognised expertise in this area to prioritise all actions as identified during this Inspection visit. This will include defining the contingency arrangements for the designated centre due to it being the designated hub once the main house is closed on the evenings.

2. All staff have completed fire training and additional training site specific training including safe evacuation procedures , completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th, and 9th April 2015.

3. The Emergency Evacuation Plan has been reviewed and updated fore this Designated Centre and it's contained within the Fire Safety Register.

4. The Night time Evacuation Plan has been reviewed and updated for this Designated Centre.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills did not evidence if evacuation was phased or total and the reduced staffing levels at night.

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. All staff have completed fire training and additional training site specific training including safe evacuation procedures , completion of fire safety register and all local fire operational procedures and documentation will be provided to staff through the engagement of a Fire Engineering Company on 2nd, 3rd, 8th, and 9th April 2015.

2. The Emergency Evacuation Plan has been reviewed and updated fore this Designated Centre and it's contained within the Fire Safety Register.

3. The Night time Evacuation Plan has been reviewed and updated for this Designated

Centre.

4. A schedule of fire drills has been agreed for this Designated Centre which will be overseen by a Fire expert.

5. The Person in Charge is currently increasing the staffing level at night time. Alongside this the Person in Charge is reviewing the internal rosters within the current compliment of staff.

Proposed Timescale: 30/04/2015

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 were numerous incidents of unexplained bruising which had not been investigate in line with policy.

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. While the Person in Charge has confirmed that incidents of unexplained bruising were and are reported through the Designated Liaison Person and Safeguarding process in line with local policy however some it has been identified that it has not been consistent in all cases.

2. The Management of the Service has engaged the expertise of an external Safeguarding Consultant to complete a full review of Safeguarding from a systems/process and implementation of the policy perspective. The first meeting to agree the scope of this review is taking place on 9th April 2015 and prioritisation will be given to the immediate auctioning and implementation of the findings.

3. The Person In Charge is currently working with the Director of Programme Quality and Safety and local Safeguarding Committee to complete a full review of incidents and associated learning with the input of multi – disciplinary members

4. A Multi-disciplinary forum will be convened for this Designated Centre which will include the Designated Liaison Person and Person In Charge and other member's of the team to review all safeguarding incidents and agreed advise practice.

5. A safeguarding standard operating procedure has been implemented within Designated Centre and each staff will be re-inducted into it with sign off.

6. All staff receive safeguarding training as part of the induction process and then training sessions are organised throughout the year.

7. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of reporting safeguarding concerns in a timely manner and the importance of completing the incident and safeguarding form correctly.

Proposed Timescale: 30/04/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An incident in which a resident had been physically restrained had not been reported to the Chief Inspector.

Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
1. An internal review has been commenced in relation to current incident reporting and notifiable event (3 day and quarterly reporting) process within the designated centre.

2. A notifiable event reporting standard operating procedure is currently in development and all staff will be inducted and educated on this once it is approved.

3. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of reporting incidents to the Person in Charge in a timely manner.

Proposed Timescale: 15/04/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal planning did not adequately demonstrate that appropriate health care was facilitated.

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. The Person in Charge is currently undertaking a review of the Individual Personal Plans. As part of this review the Person in Charge will meet with the Clinical Nurse Manager to agree timescales & review dates.

2. As part of the care plan development/review staff shall ensure multidisciplinary teams are involved in the process to ensure the appropriate healthcare is facilitated for the resident.

3. The Quality Team are conducting regular practice development sessions with staff, in regards to the importance of completing documentation adequately and reviewing care plans to ensure they reflect the resident's needs, taking into account changes in circumstances and new developments.

Proposed Timescale: 30/04/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Documentation did not support that food provided was appropriate to meet the dietary needs of residents.

Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
1. On the 9th March 2015, the Chef, Dietician and SALT met with Director of Care and Support to undertake a review to discuss the resident's preferences, choice available for residents, and ensure all residents' individual dietary needs were communicated

2. Details of each resident's individual dietary needs are specified on each of the resident's critical information sheet and eating and drinking care plan within the IPP, these are currently in the process of being reviewed and updated.

3. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of mealtime experience for the residents

Proposed Timescale: 30/04/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:
There was insufficient staff present to support residents at mealtimes.

Action Required:
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:
1. As part of the role and responsibility of the Manager/Shift Leader in each house it is their duty to ensure the following:
• The break times for all staff are agreed, ensuring there is adequate staffing levels to support the residents.
• Ensure mealtimes are planned and organised and noise levels are managed appropriately
• Ensure a supervision plan is in place for all residents, stating the level of supervision required

2. A template is in place to support the role of Manger/ Shift Leader on a daily basis.

3. The Person in Charge is currently carrying out a review to explore additional staff levels throughout the day and night. This will include also reviewing the internal rosters within the current compliment of staff to see if the resources are available.

4. The Quality Team are conducting regular practice development sessions with staff, in regards to importance of mealtime experience for the residents

Proposed Timescale: 15/04/2015

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:
There was an absence of a system to ensure that the service provided was safe, consistent and effectively monitored, specifically in relation to staffing.

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. The Clinical Nurse Manager has protected time to mentor individual staff members on a systematic approach to ensure best practices within the designated centre.

2. A Clinical Nurse Manger is assigned to the Designated Centre to provide leadership

and governance in the absence of the local Manager.

3. A Supervision Standard Operating Procedure has been developed and implemented by the Person in Charge for the supervision on staff within the designated centre to ensure consistency and adherence to care practices and processes.

4. The Quality Team are conducting regular practice development sessions with staff in the designated centre on an ongoing basis, which supports staff to gain a greater understanding of key themes e.g. meaningful day, mealtimes experience, privacy and dignity.

5. In the absence of the Person In Charge the manager/shift leader will provide supervision and leadership with the Designated Centre. A template is in place to support this role.

Proposed Timescale: 15/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence throughout the inspection demonstrated that staffing levels were insufficient particularly in relation to night time and meal times.

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. As part of the role and responsibility of the Manager/Shift Leader in each house it is their duty to ensure the following:
• The break times for all staff are agreed, ensuring there is adequate staffing levels to support the residents.
• Ensure mealtimes are planned and organised and noise levels are managed appropriately
• Ensure a supervision plan is in place for all residents, stating the level of supervision required

2. A template is in place to support the role of Manger/ Shift Leader on a daily basis.

3. The Person in Charge is ensuring additional staff is in place for night time duty. Alongside this the Person in Charge is also reviewing the internal rosters within the current compliment of staff.

4. The Quality Team are conducting regular practice development sessions with staff, in

regards to importance of mealtime experience for the residents

Proposed Timescale: 15/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised.

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. A Clinical Nurse Manger is assigned to the Designated Centre to provide leadership and governance in the absence of the local Manager.

2. The Designated centre has a Shift Leader in place. A template has been introduced to support the role of Manger/ Shift Leader on a daily basis. This encompasses a wide set of requirements including ensuring all new staff to the home are inducted using the induction template and staff are supervised appropriately throughout the day

3. A Supervision Standard Operating Procedure has been developed and implemented by the Person in Charge for the supervision on staff within the designated centre to ensure consistency and adherence to care practices and processes.

4. The Person in Charge will continue to provide individual feedback to staff on a regular basis, and ensure team meetings continue to take place.

5. The ensure staff are appropriately supervised the Person in Charge is in place.

Proposed Timescale: 15/04/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records in respect residents and maintenance of fire equipment were not accurately maintained.

Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
1. The Person in Charge confirmed that the maintenance records were up to date and centrally located by Maintenance Officer. Following the inspection, copies of these are now available in the designated centre.

2. As part of the role and responsibility of the Manager/Shift Leader in each house it is their duty to check the Fire Register and call list on a daily basis.

3. The Fire Officer has arranged to carry out fire training education with staff, which will include appropriate completion of all fire safety documentation.

Proposed Timescale: 30/04/2015