### Centre name:
A designated centre for people with disabilities operated by St John of God Community Services Limited

### Centre ID:
OSV-0002940

### Centre county:
Kildare

### Type of centre:
Health Act 2004 Section 38 Arrangement

### Registered provider:
St John of God Community Services Limited

### Provider Nominee:
Sharon Balmaine

### Lead inspector:
Conor Brady

### Support inspector(s):
Conor Dennehy

### Type of inspection:
Unannounced

### Number of residents on the date of inspection:
14

### Number of vacancies on the date of inspection:
2
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: 22 April 2015 09:00  
To: 22 April 2015 18:30

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

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**Summary of findings from this inspection**

The provider is St. John of God 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 partially 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 newly appointed person in charge, nursing staff, care 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 and protocols, meeting minutes, policies, procedures and protocols (organisational and local), governance and management documentation, staff training records and staff files.

This designated centre comprised of three separate buildings. One building was a terraced style property based on the provider’s campus while the other two buildings were detached houses in a nearby housing estate. In total the inspectors found 14 residents accommodated across these three locations with two vacant bed rooms.
According to the Statement of Purpose this designated centre proposed that it could provide services to 16 residents.

The inspectors observed both positive and negative aspects of service provision in this designated centre. However of the outcomes inspected against none were found to be in full compliance with the requirements of the Regulations and Standards. Inspectors were informed of the recent transition (2 weeks prior to this inspection) of this designated centre to another service area/model within the organisation. This involved a new management structure recently assuming responsibility for this designated centre. The inspectors found that not all staff were fully aware of such changes. For example, all staff were not aware who the person in charge was.

Inspectors found some institutionalised practices taking place in this designated centre that were having a negative impact on resident's opportunities to enjoy and participate in all aspects of their lives. These will be discussed in the main body of the report.

Overall the inspectors found that there was 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 in the following areas,

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

All of these areas are discussed in more detail in the main body of the report and in the accompanying action plan that outlines the failings identified that did not meet the requirements of the Regulations and Standards.
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 inspectors were not satisfied that all residents in this designated centres social care needs were met in accordance with the requirements of the Regulations. Inspectors noted that there were a number of resident’s personal plans that did not meet the requirements of the Regulations.

Inspectors spoke to a number of residents who presented as reasonably content with their homes and service. Many residents attended a day service (on campus) during the day time. One resident showed inspectors his bicycle and stated he enjoyed cycling on the campus. Another resident spoke about her semi-independent apartment (off campus) and expressed satisfaction at the freedom this arrangement permitted her.

Inspectors reviewed a number of residents' personal plans and found that all plans were not reviewed and up to date. Inspectors found that review dates were omitted in some cases and/or there was no evidence of resident's plans having actually taken place and/or being appropriately reviewed. For example, personal planning information not appropriately completed since 2011/2012.

In examining some resident’s person centred plans the inspectors noted goals and objectives in these plans were not always updated to appropriately reflect resident’s needs, wishes and preferences. For example, staff were able to highlight when going through resident’s plans that certain parts of the plan were not in date and/or no longer relevant to the residents. The inspectors found examples whereby outcomes were not met for residents such as residents not achieving goals/objectives such as horse riding, archery and art classes. In discussing areas that were not achieved staff highlighted 'staffing' as the primary issue in their view.
The standard of plans reviewed highlighted to inspectors that residents plans were not being kept up to date and appropriately reviewed and therefore were not guiding practice. Inspectors found that this resulted in goals and objectives not achieved for residents.

In addition, inspectors did not find that plans were based on full and comprehensive assessment as is required in the Regulations. For example, whereby modified diets were highlighted for some residents there were no speech and language (SALT) assessments regarding same. Inspectors found that plans were not in an accessible format for all residents and there was not sufficient evidence of resident input, consultation and involvement in their personal plans.

Inspectors found there was no appropriate review system regarding the monitoring and effectiveness of residents plans in this designated centre. While staff demonstrated some knowledge of residents plans it was clear that for a number of residents their personal plans did not reflect the care they received. This is not in compliance with the requirements of the Regulations.

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:
Overall the inspectors found that the arrangements in place regarding the health, safety and risk management require further improvement to meet the requirements of the Regulations.

The inspectors found that there were organisational policies and procedures in place regarding risk management. These polices included risk assessment, emergency planning and health and safety of staff, residents and visitors. These policies met the requirements of the Regulations. However, inspectors found that staff knowledge and understanding of these policies and protocols needed further improvement. For example, on arrival on this inspection the inspectors asked staff for the above policies and they were unaware of the location of same and found that these policies were not accessible to all staff.

Inspectors found that when examining the area of risk management and incident and
accident reporting there was inconsistent implementation of policy and ambiguity on the part of staff in both of these areas. For example, inspectors found risk assessments for residents that did not correlate with the residents care planning information and residents who were highlighted as requiring risk assessments (in their care plans) but did not have any completed. In addition, the inspectors found some ambiguity on the part of staff as to the reporting and recording mechanisms for incidents and accidents (This is discussed in more detail under Outcome 8: Safeguarding and Safety). The inspector found while there was a system of recording incidents and accidents, this system was not clear and appropriately managed/reviewed. This was a concern given there were behaviours of concern and related incidents prevalent in this centre.

Inspectors sought a number of incidents and accidents logs over the course of this inspection, however all of this information was not provided on this inspection. The inability to locate incident and accident documents was cited to inspectors. This issue was discussed with management at preliminary feedback and highlighted as unacceptable.

Regarding the management of fire safety, the inspectors found that there was a safety statement, fire register, evacuation plan and fire safety equipment present in the designated centre. This equipment included fire alarm panels, fire extinguishers, fire blankets and emergency lighting. Staff could highlight the assembly point in the event of an emergency to inspectors when requested for same.

Inspectors found some checking systems in place regarding fire safety. For example, staff/resident numbers check, panel check, exit checks. Inspectors found some evidence of fire drills/evacuations taking place however inspectors noted that individual evacuation plans required more clarity and needed to be updated. For example, residents highlighted as requiring the use of an evacuation chair in their care plans but not highlighted by staff as requiring same. Other individual evacuation plans were not found to be updated when residents support needs had changed.

In reviewing the training schedules provided, the inspector found that there was not evidence that all staff had undergone up to date fire training and use of fire fighting equipment.

Overall the inspectors were concerned that health, safety and risk management policies were not being implemented in the designated centre and therefore the practice and management of this area was not ensuring all residents, staff and visitors were protected.

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 that while there were organisational policies/processes regarding the protection of residents from harm and abuse, significant improvement was required to ensure the implementation, governance and management of these processes.

The inspectors found that there was a designated process assigned to deal with allegations of abuse and the centre did have procedures in place to respond to allegations, disclosures or suspected abuse. However the inspector found that staff were unclear as to these processes. For example, inspectors found that there were complaints forms, behavioural incident forms, adverse incident forms and allegations of abuse forms. Staff did not have the required understanding of these processes. For example, in speaking with staff inspectors found ambiguity in terms of what got reported and what form/mechanism was being followed.

Inspectors observed from multi-disciplinary reviews that various significant incidents had occurred with certain residents, however there were no records of these incidents on these residents care plans and staff were not aware of same. Furthermore there was no evidence of behavioural incident forms completed regarding these incidents which included acts of aggression, the management of behaviours that challenge and the application of restraint (including 'physical holds'). This poor documentation and process ambiguity made it very difficult for inspectors to see what was actually happening for residents in these instances.

Inspectors were further concerned in reviewing staff files and training records and in discussions with staff that all staff had not undergone training in safeguarding residents and the prevention, detection, response to abuse. Inspectors also found that physical restraints (holds) were being used in this centre but all staff did not have relevant and up to date training in this area. Inspectors found that the documentation regarding the use of restrictive practice/restraint was highly disorganised and not appropriately reviewed.

The inspector was concerned that in the absence of clear guidance, procedure, training, management, documentation and review that best practice was not being adhered to regarding the use of restraint within the designated centre.
All of these areas require further attention to ensure compliance with the requirement of the Regulations and Standards.

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, they were not satisfied that residents were supported to achieve and enjoy the best possible health. In addition, staff spoken with were unclear as to where particular documents were stored, reviewed or how they could be accessed. Inspectors were concerned that this could impact negatively on the delivery of safe and quality healthcare to the residents.

Inspectors reviewed the management of nutrition. Although some care plans recommended that residents were weighed on a monthly basis this was not consistently carried out. For example, residents whose weight records did not reflect being weighed in 4-5 month periods.

Inspectors found that residents plans did reflect some access to appropriate allied health professionals including, GP, psychiatry, psychology, social work, podiatry. However there was not sufficient evidence of follow up or review in certain areas. For example, speech and language therapy (SALT) and dental services where there was no evidence of residents being provided with same where required.

Inspectors found a resident highlighted as a risk of choking in care planning documentation noted as requiring a modified diet. On observing this resident dining, his meal appeared to be the same as other residents on a normal diet. On further investigation, the inspectors found ambiguity on the part of staff regarding if this resident was a risk of choking or not. Inspectors found a disconnect between care plan information and the care provided in this instance.

Inspectors found that all residents did not have an annual health assessment in place in line with organisational policy inclusive of the provision of health checks in all necessary/required areas. This assessment aimed to ensure that all residents had a full annual check up and was the organisational tool that was used to ensure residents basic
health was consistently monitored and reviewed. Inspectors found that in the absence of residents who communicated verbally, staff who were aware of healthcare needs/access to allied health professionals and appropriate assessment and documentation/records, it was not possible to determine whether residents healthcare needs were actually being met in all cases.

Regarding food and nutrition the inspectors found that the residents' living on campus were restricted in their opportunities and choice to buy, prepare and cook food. Resident's food was supplied from the campus canteen and brought to the designated centre on trays at set times. Inspectors found that residents had not been offered a choice of food on the inspection date. Inspectors found that while there were menus and set choices, residents or staff were not aware of what was on the menu on the inspection day and records showing that residents had been offered choice were found to be incomplete. Inspectors found that residents living in the locations off campus were more involved in choosing and preparing meals and were far more involved in this process.

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. The inspector found that only qualified nurses were permitted to administer medication within this designated centre.

Inspectors reviewed policy, processes and practice regarding prescription and administration and found that improvements were required. For example, The inspector found that storage of medication was cluttered and storage space was limited for all medications within the medication cupboard.

The inspectors found that there was medication present that was not in use in the medication press. The inspectors found that psychotropic "as required" (PRN) medication that was not written up on prescription documentation was found in the medication press. The inspector found that staff did not know why this medication was present.
Inspectors found that medication documentation regarding prescription and administrations of medicines was unclear and illegible in some cases. For example, staff were administering medication where prescription information was incomplete in some cases and commencement dates were not recorded in residents' prescription records. The inspectors found that administration times were not recorded regarding each medication in all cases. The inspector discussed medication errors with staff and was informed there was a reporting system for same. However given the deficits in documentation reviewed it was not clear whether this system was effective.

Inspectors found that medications that had been discontinued were not clearly signed off as such on resident' prescription documentation and medication checks marked as requiring 'double signature' were not found to have same as highlighted in policy.

The inspector found that checking systems for medication were not robust and inspectors found that medication delivery checks had not always been signed off as completed on reviewing the relevant documentation as per policy and guidelines. Furthermore there was not evidence of a quality system of review and audit of medication prescription, storage and administration within the designated centre.

Overall inspectors found that medication procedures required substantive improvement to ensure full implementation so as practices were guided by relevant/appropriate policy, best practice guidelines and regulatory requirements.

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, 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.

Overall the inspectors were not satisfied that the management systems in place to date ensured the residents were provided with a service that was fully safe, appropriate to residents needs and consistently and effectively monitored. This finding was based on the levels of non compliance found. Inspectors were informed prior to this inspection that a new person in charge was recently seconded and a new service model and management structure was in the process of being implemented for this designated centre at the time of inspection.

The inspectors found that the new person in charge met the requirements of the Regulations in terms of her qualifications, experience and knowledge and found she was appropriately aware of her responsibilities regarding the Regulations and Standards. However this person in charge was in place a short duration (less than 2 weeks) and was therefore only at an introductory stage in terms of her governance and management of this designated centre. The inspectors found that the new person in charge presented as professional and dedicated and highlighted a number of areas of change that she planned in the areas of residents care, care planning, medication management and consultation with residents.

Based on the findings of this inspection the inspectors were not satisfied that effective governance, operational management and administration of the designated centre were implemented and meeting the requirements of the Regulations.

For example, there was not the effective management and implementation of regulatory requirements in the areas of Social Care Needs, Health, Safety and Risk Management, Safeguarding and Safety, Healthcare Needs, Medication Management, Records and Documentation.

Inspectors found there was not evidence of appropriate workforce management as staff were not yet familiar with the person in charge arrangements, performance management/appropriate staff supervision had not being implemented, staff team meetings were not occurring and appropriate review of staff training requirements was not evident.

Inspectors found there was not sufficient evidence of effective auditing of the service provided to ensure residents were provided with a safe and quality service. While some auditing was found there was not sufficient follow up or implementation of audit findings. For example, health and safety and learning from incidents/accidents. All auditing/reviews were noted by the person in charge as completed by the previous manager and/or quality team. The person in charge stated she planned on completing full audits across all areas under the new model of service provision.

The person in charge highlighted that a lot of change was currently taking place within the organisation and a lot of this was necessary to work towards compliance with the Regulations. The person in charge stated she was currently reviewing all processes and highlighted staffing, training and a more direct approach to governance and
management as the plan moving forward for this designated centre.

**Judgment:**
Non Compliant - Moderate

**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 improvement was required regarding the provision of consistent and suitable staffing. 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 always meet the needs of the residents. For example, inspectors noted a number of residents who required support for medication to be administered. Inspectors found that protocol was that nursing staff only administered medication, however, inspectors found that there were occasions on the staffing roster whereby a nurse was not always on duty. Staff informed the inspector that nurses from other designated centres would have to be called on these occasions. This had an impact on residents who required regular medication and 'as required' (PRN) medication. The person in charge stated this was an area she planned on changing by training all staff in safe administration of medications so as this designated centre was not dependant on staff in other locations to be called upon to administer medications. In addition, inspectors were informed that a vacant CNM 2 position (that had been vacant for some time and was part of the centre staffing allocation) had not yet been filled.

Inspectors found in reviewing training schedules that there were gaps in staff training records. For example, manual handling training was not evident for all staff in this designated centre. Inspectors were not satisfied that staff were being provided with the necessary training and accurate training records were not maintained.

Inspectors found that agency staff were not always reflected on the staffing roster which did not make it clear who was on duty in the centre on a given date whereby agency were used. Inspectors reviewed a sample of files for staff working in the centre.
and found these files contained most of the records required by the Regulations. There were instances whereby qualifications/training were not always reflected in staff documentation. In addition, inspectors found that performance management was not conducted and a formal system of staff supervision was not evident in the designated centre. The inspectors found that all staff spoken to were not sufficiently aware of the Regulations and Standards. For example, there were not consistent team meetings, information sessions taking place whereby regulatory requirements were discussed and/or staff were appraised of specific responsibilities, e.g. updating care plans, reviewing risk assessments, updating healthcare plans. In discussing the Regulations with staff the inspectors did not find staff appropriately aware of same.

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:
Inspectors were not satisfied that policies were accessible and implemented and records and documentation were not maintained in a manner that ensured clarity, accuracy and ease of retrieval.

As highlighted throughout this report inspectors found that the standard and maintenance of documentation was poor in this designated centre. Inspectors found that residents information such as their personal care plans, health care information and recording documentation of specific care needs (e.g., dietary needs, mobility assessments, behavioural assessments and incident logs) were not maintained in line with regulatory requirements.

Inspectors found that records were not being kept under an appropriate level of review and found outdated information and residents plans that were significantly out of date that were not guiding practice. Inspectors found that the provider and person in charge were not meeting regulatory requirements in terms of implementing policy and
procedure in accordance with Schedule 5 of the Regulations. For example, risk management and medication management. In addition, inspectors found clear omissions of Schedule 3 (Residents Records) and Schedule 4 (General Records) apparent in the designated centre. For example, inspectors found large parts of residents care plans either out of date or not completed.

In addition, the inspectors found that records and documentation pertaining to medication management, restrictive practice and restraint, incidents and accidents, behavioural incidents, care planning/assessment, healthcare and staff training all required further attention. Overall the inspectors found that the records and documentation in this centre required substantive improvement to meet the requirements of the Regulations.

**Judgment:**
Non Compliant - Major

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**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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<th>A designated centre for people with disabilities operated by St John of God Community Services Limited</th>
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<td>22 April 2015</td>
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<td>Date of response:</td>
<td>24 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:
All plans for residents did not adequately reflect residents assessed needs.

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

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

**Please state the actions you have taken or are planning to take:**
a) Up to date Personal Plan will be developed for each resident in DC6 using the Personal Outcome Measures assessment; planning tool.
b) My Personal Plan File / format (MPP) will be put in place for each resident.

**Proposed Timescale:** 30/09/2015  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal 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:**
a) Accessible user friendly information in line with the residents support needs will be available in each residents MPP File.  
b) All information will be individualised in each MPP.

**Proposed Timescale:** 30/09/2015  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Personal plans were not reviewed appropriately annually or as required.

**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:**  
a) All Personal Plans will be have 1 annual review (Information gather & Planning meeting) and 3 quarterly reviews.  
b) Schedule will be put in place for each location in DC6 which will be reviewed at local staff meetings and meetings with Programme Manager and Coordinator (PIC); to ensure target dates for review of plans are maintained.  
c) Practice Development workshops will be scheduled for staff in relation to Person Centred Planning and maintaining Personal Plans.

**Proposed Timescale:**
a) By end of September 2015.
b) By end of September 2015.
c) By end of October 2015.

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not sufficient evidence of residents involvement and participation in personal planning.

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:
  a) Keyworkers will be identified for each resident.
  b) Keyworkers will be responsible for supporting the resident to plan and identify goals and support needs; involving the resident in the personal planning process.
  c) Personal Outcome Measures documentation will be used to evidence this process.
  d) Resident will be involved in all planning meetings along with family and or advocates who will form their circle of support.

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not appropriate review taking place to assess the effectiveness of plans.

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

Please state the actions you have taken or are planning to take:
  a) Each residents personal plan once developed will be reviewed quarterly (3) in a calendar year to review progress & update.
  b) Details of review, progress and any changes; new actions will be documented and maintained in MPP.
  c) Personal Plan reviews will be an agenda item at local staff meetings and house review meetings with Social Care Leader, Programme Manager & Coordinator (PIC)
Proposed Timescale:
a) By end of September 2015.
b) By end of September 2015.
c) By end of July 2015.

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

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Recording of objectives, timeframes are individuals responsible was insufficient/or not taking place at all.

**Action Required:**
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
a) Details of review, progress and any changes; new actions will be documented and maintained in MPP.
b) Personal Outcome Measures documentation will be used to track progress and reviews; along with other documentation as per MPP index.

Proposed Timescale: 30/09/2015

**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:**
There were not adequate systems in place regarding the assessment, management and review of risk.

**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:
a) Risk Management Policy for DC6 will be reviewed and updated with an action plan reflecting the risks associated with the DC.
b) Adverse incident reporting system in place. All adverse incidents reviewed by
Programme Manager and Coordinator (PIC).
c) Control measures identified for all adverse incidents to reduce the re-occurrence of adverse incident; follow up monitored by Coordinator.
d) Emergency Plan for DC6 will be reviewed and updated to reflect the support needs of residents.
e) Risk Assessment Training will be scheduled for frontline supervisors and coordinators.

Proposed Timescale:
a) By end of July 2015.
b) From end of April 2015.
c) From end of April 2015.
d) By end of July 2015.
e) By end of September 2015.

**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 (specific) in place were not in date/reviewed for certain residents and this required further attention to ensure all staff were clear on evacuation protocols and equipment required.

**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:**
a) Personal evacuation plans for all residents in DC6 updated in line with support needs.
b) All PEPs will be reviewed annually or sooner if needs change in line with personal plan.
c) Evacuation procedures / assembly point and emergency plan will be discussed at local staff meeting/s.
d) Fire drill evacuation carried out by end of May 2015 in all locations in DC6.
e) Further fire drills to be scheduled on a quarterly basis; documentation maintained.

Proposed Timescale:
a) Completed by the end of May 2015.
b) By end of September 2015.
c) By end of July 2015.
d) Completed.
e) By end of August 2015.

**Proposed Timescale:** 30/09/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff did not have up to date training in fire safety and use of fire equipment.

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:
a) All staff in DC6 will have training in Fire Safety and use of Fire equipment.
b) On the job induction sheet/record will be reviewed to include Fire Safety Precautions, evacuation procedures applicable to DC6 locations.

Proposed Timescale:
a) By end of October 2015.
b) By end of July 2015.

Proposed Timescale: 31/10/2015

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 were not appropriately trained in managing behaviours that challenge and de-escalation techniques.

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) All staff will be trained in MAPPA (managing behaviours that challenge and de-escalation techniques).
b) Schedule 1 day workshop on Multi Element Behaviour Support for staff.

Proposed Timescale:
a) By end of September 2015.
b) By end of November 2015.
**Proposed Timescale:** 30/11/2015  
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Evidence based practice was not evident regarding the management of behaviours that challenge and the implementation and recording of restraint.

**Action Required:**  
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**  
a) Behaviour Support Plans in place with specific residents in DC6 reviewed and updated to reflect best practice and rights based approach.  
b) All Behaviour Support Plans will have pro-active and re-active strategies.  
c) Re-active restrictive procedures will be approved by a multi-disciplinary team.  
d) Use of any restrictive procedure will be recorded, reviewed by staff team and relevant clinician.  
e) All restrictive procedures used will be logged and maintained by Coordinator (PIC) and notified to HIQA on a quarterly basis.  
f) Behaviour Support Plans will be reviewed on a quarterly basis or sooner if needs change.

**Proposed Timescale:**  
a) Completed by the end of May 2015.  
b) By end of September 2015.  
c) By end of September 2015.  
d) On-going since end of May 2015.  
e) On-going since end of April 2015.  
f) By end of September 2015.

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**Proposed Timescale:**  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
All staff did not have evidence that they had received appropriate training.

**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:**  
a) All staff has received training in relation to safeguarding residents and the
prevention, detection and response to abuse.
b) This training will be mandatory for all new staff commencing employment with the service.

Proposed Timescale:
a) Completed by the end of June 2015.
b) On-going.

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

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents did not have up to date healthcare assessments in their personal plans.

**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:**
a) Health Assessment will be completed for with each resident; along with action plan.
b) Health Assessment will be reviewed on an annual basis or sooner as required should health/care supports change.
c) Health Assessment will be maintained in each resident MPP File.

Proposed Timescale:
a) By end of September 2015.
b) Schedule in place by end of September 2015.
c) By end of September 2015.

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

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All residents did not have access recorded to all relevant allied health professionals.

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

**Please state the actions you have taken or are planning to take:**
a) All GP, Clinical appointments or appointments with any allied health professional will be recorded on each resident’s appointments calendar in their MPP file.
b) Details of prognosis, actions & follow up from all appointments will be recorded and maintained in relevant section of each residents MPP file.

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

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All residents were not supported to buy, cook and prepare food.

**Action Required:**
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

**Please state the actions you have taken or are planning to take:**
- Staff will receive training in basic food handling & hygiene.
- Cooking equipment required for kitchen areas will be identified and acquired.
- Meals coming from the main campus based kitchen will cease; staff will support residents to prepare meals in their own homes.
- Residents will be supported to prepare a shopping list and do daily / weekly grocery shopping in local supermarket.

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

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors found there was not choice afforded to residents at mealtimes.

**Action Required:**
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

**Please state the actions you have taken or are planning to take:**
- Choice will be made available to residents through;
  - Daily menu planning with residents.
  - Residents choosing food items in daily / weekly shopping list.
  - Shopping lists created in user friendly accessible format for residents with reading difficulties.

**Proposed Timescale:** 31/08/2015
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All residents (on campus) did not have access to food/meals outside canteen hours.

Action Required:
Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

Please state the actions you have taken or are planning to take:
a) Meals, refreshments and snacks will be made available to residents in their own home.
b) Staff will monitor supply, ensuring sufficient supply and choice available to residents on a daily basis.
c) Residents will be supported to prepare a shopping list and do daily / weekly grocery shopping in local supermarket.

Proposed Timescale:
a) By end of June 2015.
b) By end of June 2015.
c) By end of August 2015.

Outcome Timescale: 31/08/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were not appropriate professional practices found regarding the management of medication and medication documentation within the designated centre.

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:
a) Local medication management procedures will be reviewed; new procedures introduced in relation to storage, ordering, receipt, disposal and prescribing of medication.
b) New Medication Administration Record Sheet will be introduced for each resident.
c) New Cardex system will be introduced for each resident.
**Proposed Timescale: 10/08/2015**

### 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:
All staff were not aware of the lines of accountability.

**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:**
- a) Clearly detailed management structure developed and included in the Statement of Purpose for DC6.
- b) Coordinator appointed also taking on the role of PIC.
- c) Social Care Leaders will be appointed to 2 locations in DC6.
- d) Job Descriptions – roles and responsibilities will be discussed and clarified with staff teams at local team meetings.

Proposed Timescale:
- a) By end of July 2015.
- b) By end of June 2015.
- c) By end of June 2015.
- d) By end of July 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:
Management systems were not robust and did not demonstrate the effective governance and management of the designated 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:**
- a) Social Care Leaders appointed locally in DC6.
- b) Coordinator (PIC) appointed to DC6.
- c) Rosters will be re-organised to facilitate bi-weekly staff meetings chaired by Social
d) Monthly House Review Meetings will be scheduled with SCL, Programme Manager and Coordinator.
e) Terms of reference will be put in place for all meetings to ensure issues pertaining to providing a safe service; meeting residents needs will be monitored.

Proposed Timescale:
a) By end of June 2015.
b) By end of June 2015.
c) By end of August 2015.
d) By end of July 2015.

Proposed Timescale: 31/08/2015
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence of effective review of service delivery and implementation of the Regulations and Standards.

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:
a) Registered Provider Unannounced visit reports and recommendations will form part of the DCs Quality Enhancement Plan with set actions and completion dates.

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 sufficient evidence of unannounced visits and implementation of action plans resulting from same.

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:
a) All Registered Provider Unannounced visit reports will be available in each staff room in DC6.
b) All resulting action plans from Registered Provider Unannounced visit reports will be reviewed for progress on a monthly basis with each Social Care Leader in DC6 at House Review meeting with Programme Manager and Coordinator.
c) Quality Enhancement Plan will be in place for DC6.

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:
The skill mix did not always meet the needs of residents in the designated centre.

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:
a) Recruitment of Social Care Worker staff was completed for DC6.
b) Applicants are being processed and will commence on new roster/s.
c) Mandatory training and induction will be completed with new staff.
d) New staff will receive Safe Administration of Medication Training.

Proposed Timescale:
a) Completed by 16th of June 2015.
b) By 10th of August 2015.
c) By 10th of August 2015.
d) By end of September 2015.

Proposed Timescale: 30/09/2015
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The planned and actual roster did not always reflect all persons working in the centre.

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:
a) Rosters for the 3 locations at DC6 have been reviewed; new rosters will be introduced.
b) Rosters will be in compliance with regulatory requirement with planned and actual staff rota.
c) All staff working in the DC will be identified on the roster.

Proposed Timescale:
a) By 10th of August 2015.
b) By 10th of August 2015.
c) By end of July 2015.

**Proposed Timescale: 10/08/2015**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff qualifications/training was not reflected in staff files.

**Action Required:**
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

**Please state the actions you have taken or are planning to take:**
a) Personnel files for DC6 will be audited against regulatory requirements.
b) Accurate records will be maintained for all completed training.
c) Accurate records will be maintained for staff qualifications in personnel files.

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

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Training records were found to be inaccurate.

**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:**
a) The system for maintaining training records has been reviewed.
b) Going forward all training records from HR Department will reflect when training was completed.
**Proposed Timescale:** 31/05/2015

**Theme:** Responsive Workforce

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

The staff were not found to be appropriately supervised in their roles.

**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:**
- a) Coordinator (PIC) appointed.
- b) Social Care Leader appointed to provide local supervision.
- c) Performance Development reviews will be scheduled with all staff.

Proposed Timescale:
- a) By end of June 2015.
- b) By end of June 2015.
- c) By end of December 2015.

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

**Theme:** Responsive Workforce

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

Staff were not sufficiently familiar with the Regulations and Standards.

**Action Required:**
Under Regulation 16 (1) (c) you are required to: Ensure staff are informed of the Act and any regulations and standards made under it.

**Please state the actions you have taken or are planning to take:**
- a) Practice Development workshops will be scheduled to familiarise staff with the Health Act 2007 / HIQA Standards and Regulations.
- b) HIQA Standards and Regulations and compliance with same will be an agenda item at all scheduled staff meetings as per terms of reference.
- c) HIQA Standards and Regulations Folder provided to each location in DC6; staff to read and sign off.

Proposed Timescale:
- a) By end of September 2015.
- b) By end of July 2015.
- c) By end of August 2015.
Proposed Timescale: 30/09/2015

Outcome 18: Records and documentation
Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies were not found to be implemented at local level.

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:
a) Policy and Procedure folders have been placed in all staff rooms in DC6; easy access for staff.
b) All staff will read and sign off on Policy’s.
c) All residents’ personal plans will be updated into new MPP format.
d) Schedule of review of personal plans will be put in place.

Proposed Timescale:
a) completed by end of April 2015
b) By end of July 2015.
c) By end of September 2015.
d) By end of September 2015.

Proposed Timescale: 30/09/2015
Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies were not accessible to all staff in the designated centre.

Action Required:
Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

Please state the actions you have taken or are planning to take:
a) Policy and Procedure folders have been placed in all staff rooms in DC6; easy access for staff.
b) Local Policy, Guidelines and procedures will be reviewed in line with schedule 5.
Proposed Timescale:
a) Completed by end of April 2015.
b) By end of August 2015.

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All Schedule 3 documentation was not maintained in the designated centre.

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

**Please state the actions you have taken or are planning to take:**
a) All residents’ personal plans will be updated into new MPP format; in line with schedule 3 information required.

Proposed Timescale: 30/09/2015

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All Schedule 4 documentation was not maintained in the designated centre.

**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:**

a) Statement of purpose will be reviewed and updated to reflect new management structures.
b) Statement of Purpose will be kept in each staff room/location in DC6.
c) Each resident will receive an up to date resident’s guide.
d) Notifications log will be maintained by PIC in the service main office.
e) Supports Agreement to be developed with each resident in DC6; detailing supports, services and charges for each resident, in line with schedule 4.

Proposed Timescale:
a) By end of August 2015.
b) By end of August 2015.
c) Completed by 23rd of June 2015.
d) Completed by end of April 2015.
e) By end of October 2015.

**Proposed Timescale:** 31/10/2015