

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



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:	Philomena Gray
Lead inspector:	Conor Brady
Support inspector(s):	Karina O'Sullivan, Conor Dennehy
Type of inspection	Announced
Number of residents on the date of inspection:	14
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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
20 October 2015 10:30	20 October 2015 18:30
21 October 2015 10:30	21 October 2015 16:30

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

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

Summary of findings from this inspection

HIQA became significantly concerned about the safety and the quality of life for residents in St Raphael's campus, a residential service operated by St John of God Kildare Services. St Raphael's residential campus contains seven designated centres providing residential services to 137 people with intellectual disabilities.

Following the initial inspections in 2015, inspectors undertook a series of ten planned inspections to assess the progress of the provider in addressing the issues of concern which were impacting on the lives of residents.

These unannounced inspections found evidence of institutional practices, poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued a series of immediate actions, warning letters and held regulatory and escalation meetings with the provider and members of senior management.

Due to a failure of the provider to implement effective improvements for residents, HIQA issued notices of proposal to cancel the registration of three of the centres on this campus. The provider subsequently issued HIQA with plans for the closure of one designated centre, and transitional plans to provide alternative living arrangements for a number other residents which addressed the resident's safety, welfare and quality of life.

The most recent inspections have confirmed that the provider has undertaken substantive changes in governance and management across this campus. There have been improvements in staffing, persons in charge and other management positions. While there continues to be non compliances, and further improvements are required in relation to the quality of life for residents, the provider has demonstrated that they are now taking effective action to achieve these improvements.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection report specifically relates to one designated centre on this campus. This designated centre is owned and run by St. John of God Services and is located on a large campus based setting in North Kildare. The Authority was concerned about the levels and standard of care provided in this designated centre regarding the requirements of the Health Act 2007 and the associated statutory requirements of the Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013.

As part of this inspection, the inspectors met with members of management, newly appointed social care leaders, social care staff, and residents. There was no person in charge at the time of inspection but was in the processes of being recruited. 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 found residents accommodated across these three locations and met and spoke with many residents as part of this inspection.

Inspectors observed both positive and negative levels of regulatory compliance in this designated centre on this inspection. Improvements were highlighted in areas such as residents' social care needs and general welfare and development. However further improvements were required in residents healthcare, medication management and suitability of premises. While positive steps were recognised as being made, governance and management (while having undergone significant change) remained an area that required further attention in this centre to ensure regulatory compliance and positive outcomes for residents.

All areas of compliance and non compliance 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.

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 found some good examples of residents rights and dignity being promoted within the designated centre. However further improvements were required regarding promoting residents privacy, complaints procedures and the levels of consultation with residents.

Inspectors found that there was increased promotion of rights awareness since the previous inspection. A notice board contained literature regarding national advocacy, 'knowing my rights' and complaints/allegations information was observed to be in place. The two new social care leaders in post (recruited since the previous inspection) described how rights, dignity and consultation were very much on their agenda since commencing in their new posts. The inspectors noted that the staff teams working in this designated centre were made up of a lot of relatively new staff who were building relationships and still getting to know residents. This centre had undergone significant changes since the previous inspection in terms of governance and management and workforce and had transitioned to a more community model of care delivery. This will be discussed further under Outcome 14.

Inspectors found that residents had their own bedrooms and space for personal possessions and belongings.

Residents were viewed coming and going with ease in their homes and told the inspectors that their rooms had been recently painted since the last inspection and stated they had picked the colours of their rooms themselves. Inspectors observed staff speaking and treating residents with dignity and respect over the course of inspection.

Residents presented as comfortable and at ease with staff.

Inspectors spoke to a number of residents who indicated that they could approach staff and were consulted with regarding their lives. Inspectors found evidence of monthly consultation meetings with resident's and found evidence of follow up on areas identified by residents. For example, where residents had made complaints. However, the frequency and records of these consultation meetings required further attention. For example, inspectors were informed there were monthly meetings however there were not minutes in place to document same. In addition meeting minutes reviewed were not clear and did not always demonstrate dates, attendance and matters discussed.

Regarding resident privacy and dignity inspectors found that each resident had their own room and space. Some residents stated they had to lock their doors to stop other residents going into their rooms. There were instances whereby some residents rights were compromised by the behaviours of other residents however the provider had taken some action in these areas as residents made complaints regarding same. The inspectors observed one residents privacy being compromised whilst in his bedroom with the door open on this inspection. When the inspector flagged this matter to staff they closed the residents door. Aside from this, residents spoken to stated that they had sufficient privacy in their homes.

Regarding complaints, the inspectors reviewed a number of complaints and found that the provider was facilitating and responding to complaints. However the inspector found the system for the management of complaints was not robust, consistent or fully effective. For example, complaints were not being managed as per organisational policy, as written complaints were not being managed, responded to and followed up as such. This process appeared to be in transition at the time of inspection with a new template - complaints log shown to inspectors by the social care leader which was to replace the 'written complaint form'. Persons responsible for the management and review of complaints were not identifiable as is a requirement of the Regulations. Some residents were making a series of similar complaints (some of which pertained to other residents' behaviours) and a system to deal with these complaints fully and effectively was required in this centre.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

A policy in relation to communication with residents was available within the designated centre. Inspectors noted some gaps in the implementation of this policy in practice.

While it was acknowledged that many staff were new to the designated centre staff demonstrated good knowledge pertaining to some residents individual communication needs. Inspectors observed staff communicating with residents in a manner that was respectful and dignified.

However, all staff were not fully familiar with all residents communication needs and the components for the implementation of the communication policy into practice. Inspectors found that all information fields in residents communication plans were not completed and issues pertaining to residents communication needs and their likes/dislikes around this were not fully evident in all plans reviewed. There was a lack of personal communication passports within a sample of files viewed.

Judgment:

Substantially Compliant

Outcome 03: Family and personal relationships and links with the community

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were supported to develop and maintain personal relationships and links to their community. Inspectors found that families were encouraged to get involved in the lives of residents.

Inspectors found that residents were visiting their families on inspection dates and reviewed care plans that showed efforts made to maintain and strengthen residents relationships with family support structures and natural supports. Inspectors found that residents maintained phone, post box and face to face contact with families. One resident informed the inspector that she had a new born niece and was going out to shop for a gift. Another resident was posting a letter to their family on the inspection date. Another residents aunt and uncle had recently visited him in the designated centre.

In terms of links with the community the inspectors found evidence of good use of community transport/buses. Residents informed the inspectors of their community

access such as community employment, going out for meals, cinema, social outings and shopping trips. Residents were going out for coffee and were out shopping on the inspection days. Residents informed inspectors they were happy with their access to the community and opportunities to get out into the community and participate in social activities. Social care leaders explained that staff rosters were driven by residents needs and community involvement for residents was something that would be continually monitored and reviewed.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Residents in the designated centre did not have contracts for the provisions of services in place at the time of inspection. Inspectors were informed that a draft version of such a contract had been completed and a schedule to send this contract out to residents and their families was in place which was due to commence the week of inspection.

The admissions policy in operation had been reviewed at a recent inspection of another of the provider's designated centres. It was found that this policy was in need of review to ensure the process for dealing with transfers and discharge was fully included. This will be addressed under Outcome 18.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found that residents social care needs were met in this centre and noted work that had been undertaken regarding personal plans since the previous inspection. However inspectors found that while good progress had occurred some areas required further improvement.

Residents informed the inspectors that they had good opportunities to pursue interests, preferences and social activities. Residents spoke about working in the community, shopping, going on outings, using public transport every day and eating out. Inspectors found in discussing residents social lives and reviewing aspects of their social care plans, that there were opportunities for residents to pursue social activities within this designated centre.

Each location within the centre had identified a review schedule for residents plans and these were discussed at team meetings, inspectors viewed evidence of this from minutes of such meetings.

Inspectors found that each resident had a comprehensive personal plan in place. These plans highlighted many areas of residents lives such as social supports, likes/dislikes, communication needs, risk assessments and social goals. On reviewing a sample of residents files inspectors found that some plans required further attention in terms of clear dates and persons responsible to assist/facilitate residents in achieving their goals. In addition, inspectors viewed that in some instances the personal outcomes in plans directly linked to the goals identified within the person centred plan, however in another resident's plans these outcomes contradicted the residents plan. For example, one part of the resident's plan highlighted that the resident enjoyed going for campus walks while another part of the residents plan stated they disliked going for campus walks.

The social care leaders highlighted that they had completed work regarding the effectiveness of residents plans and evidence of this was seen. This was also clear from speaking to some residents about their plans. Accountability for the maintenance, review and updating of residents personal plans was discussed and has been an area that has undergone development since the previous inspection.

Judgment:

Substantially Compliant

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):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The location, design and layout of this centre was meeting its stated purpose and improvements were noted regarding the premises since the previous inspection. Residents spoken to and observed on this inspection were found to be comfortable in their homes in terms of space and premises. Inspectors noted some maintenance and refurbishment works on-going at the time of inspection. However inspectors also found there were some additional improvements required in some parts of this designated centre from a premises perspective.

The designated centre was made up of three separate locations. Two large houses were located side by side in a local housing estate and another property was part of a terraced row of houses on the perimeter of the providers campus.

Inspectors found that each resident had their own bedroom that was appropriately designed and decorated to residents' individual tastes and had adequate storage. Resident' could lock their bedrooms for privacy and had adequate space for personal belongings and clothing.

Inspectors noted kitchen areas, suitable storage and communal areas available for residents use. One property was large with a conservatory and large rear garden where residents were observed relaxing with their pet cat.

It was noted that one property was significantly smaller than the other two properties but one resident had been transitioned out of this smaller property since the previous inspection which was positive.

Inspectors found adequate arrangements in place regarding ventilation, lighting and heating. The provider had completed extensive cleaning and refurbishment internally and externally in parts of the designated centre since the previous inspection.

Residents had access to toilets and bathrooms within the designated centre however some improvement was required in this area. For example, in one location there was no bath available to residents. Residents in this property had access to one downstairs shower room. This shower was observed not working on the day of inspection but was repaired and found to be functioning on the second day of inspection. Maintenance repairs were observed to be taking place with the boiler, heating system and hot water thermostats on the inspection dates. While there was an upstairs toilet there was no

shower or bath available to residents in the upstairs in this property. Given this was a mixed gender centre and there were some associated behavioural issues/incidents that existed around expression of sexuality in this centre, this area required further attention. The Social Care Leader highlighted that the provision of an upstairs bathroom would benefit this centre in terms of providing further space for residents personal care. Inspectors did find that residents had wash hand basins in their bedrooms which they used to attend to some personal care.

In the other parts of the designated centre the inspectors found appropriate numbers of bathrooms, toilets, showers and baths available for residents use. Some residents had large bedrooms with adjoining ensembles which were observed to be of a good standard. Inspectors noted one bathroom/wet room that was in need of a deep clean and another bathroom/shower handrail that was rusting excessively and required to be replaced.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors found that the measures in place to protect the health and safety of residents, visitors and staff were appropriate in this designated centre.

A risk management policy was in place which met with the requirements of the Regulations. Inspectors reviewed accidents and incidents logs and found that any issues which required additional action had been followed up. For example where incidents took place involving residents, new risk assessments were carried out and were included in residents' personal plans while referrals to necessary allied health professionals had also been made where required. A risk register highlighted risks in the centre and categorized the level of risk and control measures in place. For example, residents at risk of falls, residents who presented with challenging behaviours, residents who travelled independently and residents who smoked, all had updated risk assessments in place.

Inspectors found that risk assessments were in place and control measures were evident in terms of risk management within the centre. Inspectors found the system of hazard identification, risk identification, assessment and management had significantly improved since the previous inspection and the provider highlighted the management focus and oversight that has been put on this area, which was evident.

Inspectors found there were adequate precautions in place to prevent against the fire. Fire drills had taken place in all three units at varying times. The results of such drills were recorded and used to inform personal evacuation plans for all residents. Residents spoken to were very knowledgeable about what to do in the event of an evacuation being necessary. Inspectors observed a maintenance and fire officer conducted weekly checks and found this person was in the centre conducting checks on the day of inspection.

Fire extinguishers, blankets, emergency lighting and the fire alarm system had been subject to maintenance checks at the regular intervals with certificates maintained. Emergency lighting was seen to be operational on inspection with exits clearly marked and evacuation procedures displayed in prominent positions in all three units.

All permanent staff had undergone up to date fire training with the exception of one who was booked for refresher training in this area in the weeks following inspection. Manual handling training had also been provided for. A training gap in the area of fire safety was identified for two agency staff members but this will be addressed under Outcome 17.

Judgment:

Compliant

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There were measures in place to protect residents being harmed or from suffering abuse. Inspectors found that residents were being protected in this designated centre and systems were in place to safeguard residents.

Inspectors found an interim policy in place and while this policy was being updated the systems of reporting in the centre were effective and inspectors found clear lines of reporting and good staff knowledge of same. Inspectors found that staff knew the different types of abuse and demonstrated awareness of risks in the designated centre. Staff knew how to report and highlighted that the number one priority in the centre was

resident safety.

Inspectors found appropriate staffing levels and training/educational safeguarding sessions provided to staff to ensure residents were protected. Residents spoken to stated that they felt safe in the centre and highlighted that staff were very approachable and accessible to them. The designated liaison person and management team had implemented safeguarding plans for residents requiring same which included multidisciplinary input and review. Each resident that required a safeguarding plan in place was found to have same.

Inspectors found that residents' requiring emotional, behavioural and therapeutic supports had been reviewed since the previous inspection and amendments had been made to residents support plans and practices within the centre. The newly appointed social care leader discussed the importance of a restraint free environment and stated that such measures would not be part of service delivery in the centre moving forward. Specific reference was made to the previous inspection and the social care leader stated that any restrictive practices would only be implemented as a last resort for resident safety. The importance of a restraint free environment was highlighted as integral by the new social care leader. Inspectors found that there was access to psychology and psychiatry for resident's to be reviewed in terms of clinical behavioural support.

Judgment:

Compliant

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed safeguarding records in the designated centre and although any issues arising in this area were appropriately managed, there was one allegation of abuse which was not notified to the Authority as required under the Regulations.

Inspectors spoke with the designated liaison person and found that the matter in question was fully assessed, managed and appropriately dealt with from the providers perspective.

Accident and incident logs were read by inspectors in all three of the centre's units. In addition all safeguarding referrals were provided by the designated liaison person. Any other incident which required notification to the Authority had been submitted within the

appropriate timeframe.

Judgment:

Substantially Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Inspectors noted that residents had opportunities for new experiences, social participation, education training and employment in accordance with the residents abilities, interest and age.

Some residents had undertaken programmes in relation to relationship and sexuality development and further residents had plans to do so. Others were employed or volunteered locally either within the larger organisation and within the local community.

Inspectors spoke with some residents who were in the early stages of transitioning to retire. Plans were already in place in relation to this on an individual person centred basis, including a reduction of working hours and the development of alternative hobbies including the establishment of a men's shed and other social activities of interest. Evidence of these developments were also reviewed within the residents files.

There was no policy available on the day of inspection in relation to access to education, training and development for the residents, this will be further addressed under outcome 18.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found that residents basic health needs were provided for in this centre. However inspectors noted that while significant progress had occurred in this area since the previous inspection, not all of the agreed actions were completed. Further improvements were required in the following areas:

-Residents Health assessments reviewed were not all completed, some areas of residents healthcare plans were left blank and incomplete. Given there was a predominantly new staff team in place (since the previous inspection) who were not fully aware of residents medical histories, this area of health planning required further attention.

-Health assessments had scheduled review dates, inspectors noticed that changes to the health status of residents were not reflected within some of the resident's health plans. An example of this was the procedural steps within a diabetic plan were not up to date nor had the centre the required equipment that was highlighted within the plan. Other residents had a completed health assessment with blank action plans attached.

-Multidisciplinary input was evident within the health section of the resident's file, however inspectors identified not all appointments with multi disciplinary members were known by staff or documented within the residents health check calendar.

- There were deficiencies noted in relation to the recording and implementation of aspects of health care needs. For example the monitoring of blood glucose levels, 41 recording's were obtained incorrectly in the sample reviewed. When discussing this with staff members only one member of staff who had recently commenced within the designated centre had received training in relation to the management of diabetes. Training of staff will be further addressed under outcome 18. Guidance in relation to the transportation and management of sharps within the designated centre was unavailable on the day of inspection.

- Some monitoring or other actions within residents healthcare assessments were not evident in some files viewed for example monthly urinalysis for one resident.

Regarding food and nutrition inspectors found improvements in this area since the previous inspection. Inspectors found residents participating in meal times within the designated centres was evident and had improved since the previous inspection. Residents assisted staff in meal preparation and participated in menu planning. Inspectors viewed user friendly menu selection and weekly shopping list. These reflected the individual needs within the designated centre such as low cholesterol products. Meals were no longer coming from the designated centre form a central kitchen inspectors observed cooking equipment within the designated centres.

Refreshments and snacks were available for the residents outside mealtimes within the designated centre.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

While some improvements had been made in the storage of medication the accuracy of medication records was not sufficiently maintained to assure inspectors that best practice was being followed.

Inspectors reviewed the prescription and administration records in all three of the centre's units and found various discrepancies in such documentation. For example on three different days one resident was listed as receiving two different forms of medication on three occasions. However as per the prescription records for this resident such medication was to be administered twice daily. While inspectors were assured that this was a documentation error only it was noted this same error occurred on three separate days and involved three members of staff.

The Social Care Leader of the unit where these errors took place informed inspectors that the procedure of reporting medications errors had been followed and the staff members involved were reintroduced into the medication policies and procedures in operation. However a similar error was also observed for a second resident in the same unit which the Social Care Leader was unaware of. In addition an incident report was read by inspectors which showed that a resident in another unit was incorrectly administered a third dose of a prescribed antibiotic the week before this inspection took place. The provision of medication training will be further discussed in Outcome 17.

Further errors and omissions were also found across all three units. A discontinued medication on one resident's prescription was crossed off and did not have any discontinued date nor was signed for by a GP. The route of administration was not consistently recorded on prescription sheets while the times recorded for administration for some medications did not match the times on prescription sheets. Inspectors were shown new administration record sheets which more clearly stated the times of administration. These sheets were not yet in use at the time of inspection.

New arrangements for the storage of medication had been put in place since the previous inspection in one of the units. While secure storage was available in the other two units it was noted that this storage space was limited and cluttered. While reviewing the medications stored in one unit an unlabelled box of tablets was found. The staff member present did not know which resident this medication was for. As per the provider's own procedures, daily stock checks of medication were to be carried out. However it was noted across all three units that such checks were not being conducted on a daily basis.

Suitable facilities for the storage of medication requiring refrigeration were available and daily temperature checks were recorded. PRN protocols were in place for all residents. It was noted on one such protocol that the minimum time between administrations differed from the minimum time stated on the corresponding prescription sheet. The errors relating to medication records will be actioned under Outcome 18.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

A Statement of Purpose was in place that described the service provided in the centre which met the requirements of the Regulations.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found that while there had been an improvement in a number of areas pertaining to governance and management further improvements were required. Inspectors found that there was not a person in charge in post at the time of inspection and no annual review had taken place in the centre since commencement of the Regulations.

Persons participating in the management of this centre gave assurances that a new person in charge had been recruited and would be in position in November 2015. The position of person in charge was vacant from 28 August 2015 and oversight was being provided by the Programme Manager and two social care leaders in the interim.

The person participating in the management (Programme Manager) of this centre had assumed responsibility for this centre following the previous inspection and moved the centre towards a community model of care delivery. Two new social care leaders had been recruited which were two new posts. Both of these persons were in place at the time of inspection and demonstrated good knowledge and competence in their role. The new management structure had been communicated with all staff and this structure would be completed with the appointment of the new person in charge. Inspectors found a completely new staff team in place since the previous inspection.

The inspector found that the managerial emphasis on areas of risk, resident safety and quality of care had improved since the previous inspection. Management meetings, reviews and direction demonstrated this and an increased regulatory awareness was evident in the designated centre. It was clear that substantive change had occurred at a number of levels in this designated centre and more accountability was now being promoted within the centre to ensure continued movement toward regulatory compliance. For example, reviewing of residents plans, new policy/protocols, workforce/personnel changes and supervision. Inspectors found that this change was improving outcomes for residents.

The inspector found a quality enhancement plan was reviewed and this plan was creating action plans that were being followed up by management. However the provider had not yet conducted/concluded an annual review of the quality of safety of care and support which is a requirement of the Regulations. The provider stated at the outset of this inspection that work was being completed on this plan and a review of 2015 would be made available.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors found that there were systems in place to manage the designated centre in the absence of the person in charge.

As there was not a person in charge in place at the time of this inspection, the centre was being managed by the Programme Manager and two Social Care Leaders. The inspectors found that this system was operating effectively and residents and staff were aware of who was managing the centre in the absence of a nominated person in charge being in post.

The Programme Manager and Social Care Leaders were aware of the requirement to notify the Authority of arrangements in place regarding any absences of the person in charge.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found that the designated centre was provided with appropriate resources to ensure the effective delivery of care and support.

Inspectors found that appropriate finances, budget, transport and staffing were available to residents in terms of their assessed needs. Residents had access to transport when required and residents spoken to stated they were happy with the levels of resources available within the centre. Any issues pertaining to facilities and premises have been highlighted under Outcome 6.

Judgment:

Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Improvement had been made regarding the provision of consistent and suitable staffing. However some training gaps were again identified.

Inspectors found that there was sufficient numbers of staff in place to meet the needs of residents. Since the previous inspection two new Social Care Leaders had been appointed and new staff teams had been put in place specific to each of the three service units. This helped to ensure a greater continuity for residents while the Programme Manager informed inspectors that she was working on developing a regular relief panel. Rolling rosters were now in place and all staff working in the units, including agency staff, were identified on the rosters. A programme of performance review was also in place since the previous inspection.

The skill mix of staff continued to require review. Inspectors reviewed a sample of staff files and training records. While there were some discrepancies between these, as will be discussed under Outcome 18, it was evident that training gaps were present. For example no evidence could be provided that two agency staff had undergone training in fire safety. In addition, there was no evidence of one of these staff members having undergone any training in the area of medication. However despite this he was rostered for lone work in one of the units on four days during the week of inspection. The Programme Manager informed inspectors that a nurse from a nearby designated centre would visit the unit for the purpose of administering medication if required.

In relation to the medication errors discussed under Outcome 12 it was stated to inspectors that one of the staff members involved had not received training in medication management at the time of these errors but had since been moved to another nearby designated centre where he was not administering medication.

Permanent staff had received training in the areas of fire safety, safeguarding and safe administration of medication. However it was noted that only one staff member had received training in the area of diabetes management in one of the units where diabetic residents resided. In addition it was not clear if all staff in one unit had received training in food handling and hygiene. Training schedules were shown to inspectors which did include training in such areas.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The standard and maintenance of documentation within the designated centre had improved but further work was required. Inspectors found that not all of the required policies had been updated as required.

As mentioned under Outcome 17 the accuracy of training records required further attention. Lists were provided to inspectors highlighting training courses associated with staff members working in one of the units. Although these courses occurred in the past many had a status of "Scheduled" while a review of staff files did not provide corresponding training certificates for all of these courses. This issue had been highlighted to the provider on the previous inspection.

A different training list for all three units was provided to inspectors on day 2 of inspection however this did not completely match the lists seen on day 1. Subsequent to

the inspection additional records were provided which showed that permanent staff had received training in areas such as safeguarding and medication. The accuracy of training records has been highlighted on multiple inspections with this provider since March 2015 but at the time of this inspection no progress had been made in addressing this area.

Policies within the designated centre were more accessible than during the previous inspection while staff were aware of such policies. However some policies such as admissions, intimate personal care and safeguarding required review or had not been updated at the three yearly intervals as required by Regulations. In addition a policy covering the access to education, training and development was not in place at the time of inspection.

In line with the development of new personal plans residents' information was more accurately maintained. However it was noted that some of the information contained within these was out of date or not signed off by a member of staff. It was also noted that some of the information in one resident's personal plan in fact related to another resident. Records of personal possessions were not in place for all residents.

A residents' guide and directory of residents were in place, both of which met the requirements of the Regulations. All other documentation requests made by inspectors were provided for.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Conor Brady
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0002940
Date of Inspection:	20 and 21 October 2015
Date of response:	15 December 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:

Residents privacy was observed to be compromised in this centre on the day of inspection.

1. Action Required:

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

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:

The Registered Provider will ensure that the intimate care plan for resident identified and other residents with similar needs in the Designated Centre will be updated to reflect verbal and physical prompting in relation to closing of doors and privacy during intimate care.

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

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

Further improvement was required regarding the frequency and recording of residents' opportunities to be consulted within the designated centre.

2. Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

The Registered Provider will ensure that local speak up meetings will be scheduled monthly and minutes will be recorded in S.M.A.R.T format.

Copies of speak-up meeting minutes will be forwarded to the Person in Charge for monitoring of outcomes and filing.

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

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

The complaints procedure that was operating in this centre was not effective.

3. Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

The Registered Provider will ensure adherence to the complaints process and local procedure.

The Programme Manager is identified as the person responsible for the review and sign off of processed complaints.

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

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

The complaints made were not being comprehensively managed in line with policy and regulatory requirement. There was no record regarding the satisfaction of the complainant following the response/action taken.

4. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

The Registered Provider will ensure adherence to the complaints process and procedure in place in the centre.

Complaints will be reviewed monthly at House review meetings by Social Care Leader, Person in Charge and the Programme Manager, to monitor status, outcome and satisfaction of individual complaints to the centre.

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

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

There was no oversight role identified highlighting a person available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

5. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

The Registered Provider will ensure that all complaints are appropriately responded to, through the review process now in place.

The Person in Charge and Programme Manager will maintain complaints log and review monthly at house review meeting with the Social Care Leader.

Proposed Timescale: 31/12/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

All residents communication plans were not completed and the communication guidance available for staff required some improvements.

6. Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

The Person in Charge will ensure communication plans and passports for identified residents will be completed fully in line with resident's needs.

Proposed Timescale: 31/01/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Residents did not have contracts of care in place.

7. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

A. Contracts of care have been sent to resident's families on week commencing 16th Oct 2015 for consultation.

B. The Registered Provider will ensure signed contracts of care will be in place in residents personal plans.

Proposed Timescale:

A. By 16th October 2015 (completed)

B. By 8th of January 2016

Proposed Timescale:

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 were not clearly defined actions for all residents annual goals and social objectives highlighting persons responsible and timeframes.

8. 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:

The Person in Charge will ensure that each resident has an annual review with three quarterly reviews in the year, completed by residents and their key workers.

All actions/Goals resulting from above reviews will be in S.M.A.R.T format.

The Social Care Leader will manage this process of reviews and the quality of same.

The Person in Charge will also monitor the process and quality through audit of the reviews and feedback.

Proposed Timescale: 31/01/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

All parts of the centre were not suitably clean.

9. 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:

The Person in Charge will ensure a deep clean of identified bathroom is carried out and that a cleaning schedule is put in place to ensure cleanliness is maintained.

The Person in Charge will ensure that the rusting hand rail identified will be replaced.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

All requirements of Schedule 6 were not met regarding the provision of baths, showers and toilets in all parts of the designated centre.

10. Action Required:

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

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

- A. The registered provider has completed a review of bathroom facilities on the 10th December 2015.
- B. One bathroom was identified for the installation of an additional shower.
- C. Additional shower will be installed to meet the needs of all residents.

Proposed Timescale:

- A. By 10th December 2015 (completed)
- B. By 10th December 2015 (completed)
- C. By 20th February 2016

Proposed Timescale:

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:

All notifications of any allegation, suspected or confirmed, abuse of any resident were not reported to the Authority.

11. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

- A. The Person in Charge will ensure all notifications of any allegation of abuse of a resident, suspected or confirmed will be notified to the authority on NF06 form within three working days.

B. The Person in Charge will keep a log of all notifications to the authority.

Proposed Timescale:

A. By 15th November 2015 (completed)

B. By 15th November 2015 (completed)

Proposed Timescale:

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Health care plans and areas of health care such as diabetes management required further action to ensure all areas of resident healthcare were appropriately provided, recorded, reviewed and updated on a consistent basis.

12. 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. The Registered Provider will ensure all healthcare plans are reviewed annually and on a quarterly basis in line with personal plan review process.

B. All actions resulting from above reviews will be in S.M.A.R.T format.

C. The Person in Charge will ensure the Social Care Leader manages this process of reviews and the quality of same.

D. The Person in Charge will also monitor the process and quality through audit of the personal plans.

Proposed Timescale:

A. By 31st January 2016

B. By 31st January 2016

C. By 31st January 2016

D. By 30th June 2016

Proposed Timescale:

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:

Medication was not administered in line with best practice.

13. Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

- A. The Person in Charge will ensure the local policy and procedures on medication management and administration is adhered to, by all staff in the Designated Centre.
- B. A medication management and administration audit will be completed.
- C. All medication errors will be reported to the Person in Charge then reviewed and followed up with appropriate action as necessary.

Proposed Timescale:

- A. By 15th November 2015
- B. By 28th February 2016
- C. By 15th November 2015

Proposed Timescale:

Outcome 14: Governance and Management
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Theme: Leadership, Governance and Management

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

There was no person in charge appointed and in place at the time of inspection.

14. Action Required:

Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

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

Person in Charge has been appointed and is in post since the 2nd of November 2015.

Proposed Timescale: 02/11/2015

Theme: Leadership, Governance and Management

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

There was no annual review of the quality and safety of care and support in the designated centre since commencement.

15. 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:

The Registered Provider will ensure that an annual report on quality, safety, care and support will be completed by the 31st of January 2016 for year ending December 2015

Proposed Timescale: 31/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

All staff working in the centre were not appropriately trained.

16. 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 Person in Charge will ensure that an identified relief panel of Social Care Relief Workers is in place.

B. The Person in Charge will ensure all staff, permanent, relief and agency have completed safeguarding, Fire safety, manual handling and safe administration of medication training when due for renewal.

C. The Person in Charge will ensure that all agency staff has training records that are compliant with the regulations from 15th December 2015.

D. The Person in Charge will ensure that a training schedule for 2016 is developed.

Proposed Timescale:

A. By 28th February 2016

B. By 15th December 2015

C. By 15th December 2015

D. By 8th January 2016

Proposed Timescale:

Outcome 18: Records and documentation

Theme: Use of Information

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

A policy on access to education, training and development was not in place.

17. 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. The Registered Provider will ensure that all policies and procedures set out in schedule 5 set out in the health act will be updated.

B. A policy on access to training and development for people using intellectual disability services has been developed and will be launched.

Proposed Timescale:

A. By 31st March 2016

B. By 31st January 2016

Proposed Timescale:

Theme: Use of Information

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

Policies had not been updated at 3 yearly intervals or to reflect changes in National Policy.

18. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The Registered Provider will ensure a schedule is in place to review policies not exceeding three yearly intervals.

Proposed Timescale: 31/03/2016

Theme: Use of Information

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

Some resident information in personal plans was not properly maintained. Medication records were not accurate.

19. 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. The Registered Provider will ensure personal plans are reviewed on a quarterly basis by the keyworkers in the Designated Centre.
- B. All actions/Goals resulting from above reviews will be in S.M.A.R.T format.
- C. The Social Care Leader will manage this process of reviews and the quality of same.
- D. The Person in Charge will also monitor the process and quality through audit of the reviews and goals set.
- E. The person in charge will ensure an audit of personal plans is carried out by the.

Proposed Timescale:

- A. By the 30th January 2016
- B. By the 30th January 2016
- C. By the 30th January 2016
- D. By the 30th January 2016
- E. By the 30th June 2016

Proposed Timescale:

Theme: Use of Information

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

It was not possible to ascertain the accuracy of training records provided.

20. 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. The Person in Charge will ensure all training records and reports are fully maintained at local level, with evidence of attendance.
- B. The Person in Charge will ensure a training schedule is in place to monitor training needs into the future.

Proposed Timescale:

- A. 15th December 2015
- B. 8th January 2016

Proposed Timescale:

