Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003646
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Clare Dempsey
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
04 March 2016 10:10	04 March 2016 18:10

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This announced inspection was the centre's first inspection as a stand-alone designated centre. Previously the centre had been part of another designated centre comprising a number of residential units.

The purpose of this inspection was to monitor the level of compliance with the regulations. The centre was a spacious, detached residential dwelling on the outskirts of a small town in County Louth and was part of St. John of God's North East Services.

Eight outcomes were inspected against and the inspector found evidence of good practice across all outcomes. Some improvements were required with regard to social care needs assessment, fire containment measures and recruitment information in staff files.

The inspection took place over one day and as part of the inspection process, practices were observed and relevant documentation reviewed such as care plans, healthcare records, policies and procedures. The inspector also met with and spoke with residents and staff.

The person in charge was not available to facilitate the inspection, so the team leader, who is also the person participating in management, did so. They were found to have a comprehensive knowledge of residents, their personalities and support needs. Also, they were engaged in the supervision of staff and practices in the centre on a regular basis. They worked on the roster alongside staff during the week and had an allocated 12 hours administration time in order to meet their responsibilities regarding duty rosters and auditing, for example.

There were some non-compliances found on the inspection that required addressing by the provider and person in charge. Residents' personal plans contained comprehensive assessments of need and also included support plans where a need had been identified. However, residents' social care assessments were not up-to-date and dated back to 2014 in some instances. While there were adequate fire safety management procedures in the centre, there were inadequate systems in place for the containment of smoke and fire in one area of the centre. The fire panel was inappropriately located in a resident's bedroom and did not adequately support the resident's privacy. A sample of staff files were reviewed as part of the inspection to ascertain if they contained the matters as set out in Schedule 2 of the regulations. One file did not meet the regulations, as it did not contain an employment history or vetting for a staff member.

Of the eight outcomes assessed, four were found to be compliant or substantially compliant with four moderate non-compliances found in Outcome 1; Rights, Dignity & Consultation, Outcome 5: Social Care Needs, Outcome: 7 Health & Safety & Risk Management and Outcome: 17 Workforce.

The findings to support these judgments are in the body of the report; the action plan with the provider’s response in addressing the identified failings is found at the end of the report.

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

Outcome 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):
This was the centre's first inspection by the Authority.

Findings:
Not all aspects of this outcome were reviewed on inspection.

The fire panel for the centre was located in a resident's bedroom. This meant the resident's private space was intruded upon when staff needed to carry out routine checks of fire safety such as activating the fire alarm from the panel for carrying out fire drills or determining where a smoke alarm was sounding from in the event of the fire alarm sounding.

This issue had already been identified through provider led audits of the centre; however, at the time of inspection it had not been addressed.

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Residents' social care needs had been adequately assessed as evidenced in their personal plans. Support plans were in pace to manage and support their identified needs and were comprehensive. However, residents' social care assessments of needs were not always up-to-date with some dating from 2014.

Residents' personal plans supported them to have opportunities to participate in meaningful activities, appropriate to their interests and preferences. For example, from a sample of files viewed residents engaged in meaningful community based activities on a regular basis. Residents used the local shops, hairdressers and frequented the local pubs, restaurants and hotels. They had gone on holidays and used the facilities in the hotel to the fullest, accessing the restaurant and spa facilities during their stay.

The arrangements to meet each resident's assessed needs were also set out in their individualised personal plans. Personal plans documented residents' interests, preferences and capabilities. Residents, their family members and, or representatives were also consulted and involved in reviewing plans. From a sample of files viewed it was evident that family members attended circle of support meetings where possible.

Short and long-term goals had been achieved for residents living in the centre. There was evidence to indicate they had been reviewed and updated.

While in the main residents' personal plans were comprehensive and detailed, the original assessment of needs dated back to 2014 in a number of instances. Residents had not received a comprehensive annual review of their social care needs in line with regulation 5 (6) which sets out residents' personal plans are to be reviewed annually or more frequently if there is a change in needs or circumstances.

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):
This was the centre's first inspection by the Authority.

Findings:
The health and safety of residents, visitors and staff were promoted and supported in the centre. However, some improvement was required to ensure that all risks were identified. Some measures for the containment of smoke and fire in the centre required improvement.

A risk management policy which met the requirements of the regulations was in place, in addition to a centre specific health and safety statement. An emergency plan was also in place which outlined the steps to be taken for a number of emergencies such as fire, power failure and adverse weather conditions. This plan also provided for alternative accommodation if required.

There was no risk register in place at the time of inspection as it was being drafted. Without a working risk register in place the provider and person in charge could not comprehensively audit risk management procedures in place for the centre to ensure they were adequately providing for residents', visitors' and staff health and safety in the centre.

Personal risks identified for residents had been risk assessed and rated using a risk matrix system. The impact and likelihood of the personal risk occurring had been established and associated risk control measures documented and in place. While this was evidence of good risk identification and management there were two different kinds of templates in use. The most up-to-date template provided for comprehensive assessment of personal risk, while the older template in use did not set out the decision making process or rationale for the identified risks and was therefore not adequate.

A fire register was maintained which contained records of fire drills carried out in the designated centre. These drills took place at varying times of the day with observations recorded. Personal evacuation plans were in place for all residents. Staff spoken with during the course of inspection informed the inspector what they would do in the event of an evacuation being necessary. They identified various methods of fire containment and had knowledge of residents' support needs.

Emergency lighting was operational throughout the designated centre, fire exits were unobstructed. The fire extinguishers, emergency lighting and fire alarm were also subject to regular maintenance checks with records of such checks available for inspectors to review. Regular internal checks were also carried out and recorded for fire equipment in the centre.

However, a door leading from the utility room leading to the kitchen, which contained two washing machines and a dryer, did not have adequate measures in place to contain the spread of smoke or fire should it occur. As the utility room could be identified as a space that could pose a risk for fire and smoke occurring, the provider was required to ensure adequate measures were in place for its containment.

Infection control measures in the centre were adequate given the purpose and function of the centre. There were adequate hand washing facilities throughout, paper hand towels were in use and alcohol gel was in supply in the centre.

Judgment:
Non Compliant - Moderate

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:
There were adequate systems in place to protect residents from abuse. Residents received supports to manage behaviour that challenges with an emphasis on the least restrictive intervention necessary. Restrictive practices were reviewed by the organisation's governance of restrictive practices committee who had a responsibility to review and challenge the necessity for any restrictions in place to support residents throughout the service.

There was a policy on, and procedures in place in relation to safeguarding vulnerable adults which provided guidance to staff in the prevention, detection, response and management of alleged and actual abuse of vulnerable adults. Staff had up-to-date training in vulnerable adult protection.

Staff spoken with were respectful in their description of residents and demonstrated knowledge in relation to what constitutes all forms of abuse and reporting procedures. The team leader, who was also the person participating in management (PPIM) on the day of inspection, also informed the inspector that there was a designated person to co-ordinate the management of any allegations of abuse.

The organisation had a policy in place for the provision of intimate personal care as per the matters set out in Schedule 5 of the Care and Welfare Regulations 2013 (as amended). Intimate care plans were in place to provide comprehensive guidance to staff ensuring, consistency, privacy, dignity and personal integrity for each resident. Intimate care plans were found to be detailed and focused on supporting the resident to maintain as much independence as possible.

There were some restrictive practices used in the centre. However, they were found, in the main, to be for the safety of residents rather than the management of specific behaviour that challenges or to pose unjustified restrictions for the person.

A small gate was fixed to the side of the kitchen counter top in the centre which when closed prevented residents from entering the space near the cooker when meals were being cooked. It had been determined that some residents were at risk of scalds or burns during cooking times as they could enter the space and pull at boiling pots or the kettle. The inspector observed the gate was not used during the inspection and residents entered the space freely to get snacks and drinks as they wished.

Other restrictive practices in place included specific prescribed physical restraint holds implemented by staff when residents were having blood taken for necessary tests. These physical restraints had been prescribed by a qualified instructor and closely observed as they were implemented with written documentation evidencing residents had not been adversely affected during the procedures and had participated well.

All residents living in the centre could from one time to another engage in behaviour that challenges, some of which was associated with deteriorating mental health, for example. Residents requiring the support of mental health services had received regular, comprehensive supportive review by their psychiatrist with good results.

All residents had support plans in place to guide staff in the management of instances of behaviour that challenges. While there were comprehensive management processes in place for residents, the documented support plans did not reflect the rich knowledge that staff demonstrated to the inspector of how they managed specific situations. In particular when a resident engaged in escalated, intense behaviour that challenges which could result in serious risk to them and, or others.

Judgment:
Substantially Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Residents' healthcare needs were well supported in the centre. Their healthcare was reviewed and monitored closely with the support of allied healthcare professionals. Associated support plans were in place in line with allied healthcare professional

recommendations and residents had also been supported to avail of preventative health screenings.

Healthcare needs were met in line with personal plans and through timely access to appropriate healthcare services and treatments with allied healthcare professionals. Records showed that routine visits were organised as and when required to the General Practitioner (GP), and allied healthcare professionals such as a dentist, physiotherapist, dietician and optician.

Specific issues were comprehensively provided for, such as epilepsy, mental health and nutrition and weight management. All residents living in the centre could experience seizures related to epilepsy. Each had appropriate emergency management of epilepsy procedures in place and prescribed medication. There were other systems in place which would alert staff should a resident experience a seizure during their sleep. Epilepsy specific monitors were used for this purpose.

All residents had received a bone density scan with the exception of one who had declined to participate. Access to this preventative health screening was particularly important given the age and sex of the residents that lived in the centre and their possible predisposition for developing brittle bones due to long-term use of anti-convulsants for the management of epilepsy.

Residents were supported to have input into the weekly menu planning and individual preferences were provided for. Food was varied, fresh and nutritious. Residents' nutritional risk was carefully monitored through the regular assessment of their weights, Body Mass Index (BMI) and calculation of nutritional risk through the use of an evidence based nutrition risk assessment.

Residents identified as being at risk of losing weight had been seen by a dietician and prescribed nutritional supplements which they were given to prevent weight loss and help them maintain a healthy body weight.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Overall the inspector found medication management met with good compliance. Written operational policies and procedures were in place for the safe storage, administration and disposal of medications.

Medications were securely stored in a locked storage unit. No medications required refrigeration. Residents requiring crushed or modified consistency medications were prescribed such in liaison with the resident's GP and pharmacist and this was documented on medication administration recording sheets.

Staff working in the centre had completed medication management training and there was evidence of refresher training in staff records. Some residents were prescribed medication as a first response in the management of epileptic seizures. Staff had also received training in administration of this medication.

No residents engaged in self-medication practices.

Regular medication management audits had taken place and noted any discrepancies or practices not in line with the organisation's policies and procedures for safe medication management. Items were addressed as they arose.

The person participating in management of the centre informed the inspector that residents had recently changed to another pharmacist for their medication provision needs and found the pharmacist to be supportive and informative with regards to the residents' pharmaceutical needs and requirements.

Each resident received their medication in a blister pack format, which was prepared by the pharmacist. The PPIM outlined that this system had reduced the amount of out-of-date medication in the centre and also reduced the number of medications that needed to be returned to the pharmacy due to excess stock.

There had been no medication errors in the three months previous to the inspection.

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):
This was the centre's first inspection by the Authority.

Findings:
The person in charge of the centre was not available on the day of inspection. The person participating in management (PPIM) of the centre or team leader facilitated the inspection. They were a suitably qualified person with experience and knowledge commensurate to their role.

The PPIM had taken up their position a year previously and demonstrated a good knowledge of the running of the centre and regulations. They demonstrated a comprehensive understanding of organisational policies, procedures and regulatory responsibilities.

The person in charge worked in a full-time post. The PPIM also worked full-time hours. These hours included allocated administration time with the rest of the time working on roster alongside staff. This allowed the PPIM to observe practices and engage in a meaningful way with residents.

Unannounced and announced visits from the provider and persons nominated by the provider had occurred in the centre with documented evidence of the outcomes of the visits and issues of compliance and non-compliance found and acted on, where necessary. A number of other key clinical indicator audits had been carried out by the person in charge relating to medication management and infection control, for example.

The inspector was assured there were continuous efforts being made towards high standards and compliance by the provider and management of the centre. Audits carried out had been comprehensive and identified specific issues related to the care and welfare of residents. Audits reviewed were robust and had brought about changes and improvements in the standard of support residents received.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
The centre had a staff team who worked collaboratively to ensure the needs of residents were met.

Residents appeared comfortable in the company of the team leader (PPIM) and staff. Interactions appeared relaxed with a genuine rapport evident between residents and staff. During the inspection, the inspector observed staff carrying out supports and practices with residents and found that they were supportive and appropriate.

Staff training records viewed by the inspector confirmed all staff had completed up-to-date mandatory training. A continuous training programme had been implemented and records were maintained. Some areas of training staff had completed were medication management, nutritional risk assessment and management of behaviour that challenges.

There were suitable arrangements in place to ensure staff received supervision and support on a regular basis. The person in charge and team leader (PPIM) engaged in active supervision of staff working in the centre. This occurred through formalised meetings and also direct supervision where the PPIM worked on the roster alongside staff during the week.

A small sample of staff files were reviewed as part of the inspection. However, they did not meet fully with the matters as set out in Schedule 2 of the regulations. One staff member's file did not include an employment history or vetting. This was brought to the attention of the Human Resources manager.

The Human Resources manager put measures in place to expedite the vetting process. In the meantime, until vetting was received, the staff member would only work day shifts and under supervision. It was established that this anomaly had been an oversight and there were no concerns with regards to the staff member's abilities or suitability to support vulnerable adults.

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:

Ann-Marie O'Neill
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 report[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0003646
Date of Inspection:	4 March 2016
Date of response:	15 April 2016

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:
The fire panel for the centre was located in a resident's bedroom. This meant the resident's private space was intruded upon when staff needed to carry out routine checks of fire safety such as activating the fire alarm from the panel for carrying out fire drills or determine where a smoke alarm was sounding from in the event of the fire

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

alarm sounding.

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

Please state the actions you have taken or are planning to take:
1. The fire panel will be relocated to the hallway of the premises.

Proposed Timescale: 30/04/2016

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:
Residents had not received a comprehensive annual review of their social care needs.

2. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
1. A comprehensive review of all resident social care needs has commenced and will be complete by 30.05.16

Proposed Timescale: 30/05/2016

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 was no risk register in place at the time of inspection as it being drafted. Without a working register in place the provider and person in charge were could not audit risk management procedures in place for the centre to ensure they were adequately providing for residents', visitors and staff health and safety in the centre.

The most up to date template provided for comprehensive assessment of personal risk, while the older template in use did not set out the decision making process or rationale for the identified risks and was therefore not adequate.

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

Please state the actions you have taken or are planning to take:
1. There is only one risk register now in the Designated Centre comprising all risks within the centre; this is an active and on-going document.

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A door leading from the utility room which contained two washing machines and a dryer, to the kitchen did not have adequate measures in place to contain the spread of smoke or fire should it occur in the room.

4. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
1. The door leading to the utility room has been replaced with a fire door.

Proposed Timescale: 05/03/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The documented behaviour support plans did not reflect the rich knowledge that staff demonstrated to the inspector of how they managed specific situations, in particular when a resident engaged in escalated, intense behaviours that challenge which could result in serious risk to them and/or others.

5. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
1. All Behaviour Support Plans in the centre are being update to include the knowledge that all staff have of the residents.

2. All staff will be inducted into the up dated Behaviour Support Plans.

Proposed Timescale: 30/04/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One staff member's file did not include an employment history or vetting.

6. 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:
1. An Updated History of employment for the staff member was sent to the authority on 10.03.16
2. A Copy of Self-Declaration Form dated 5th March 2016 and Garda Clearance Form dated 5th March 2016 which has been forwarded to the Garda Vetting Office for processing were sent to the authority on 10.03.16.
3. The current Garda vetting for the lady was returned from the Garda Vetting office on 8.04.16 and is on the personnel file and notification/ copy of up to date vetting sent to the Authority 8.04.16

Proposed Timescale: 08/04/2016