<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by RehabCare</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002644</td>
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<tr>
<td>Centre county:</td>
<td>Clare</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td>Registered provider:</td>
<td>RehabCare</td>
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<tr>
<td>Provider Nominee:</td>
<td>Rachael Thurlby</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tr>
<td>02 February 2016 09:15</td>
<td>02 February 2016 18:30</td>
</tr>
<tr>
<td>03 February 2016 09:15</td>
<td>03 February 2016 18:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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

This inspection was the first inspection of the centre by the Authority.

Residential services were provided to four young adults and the centre was fully occupied. The inspection was facilitated by the person in charge and the team leader (person participating in the management of the service (PPIM)); the regional manager was also present on both days of inspection.
These inspection findings were informed by records reviewed, staff spoken with, feedback received from families who completed the Authority's questionnaire and the inspector's observations while in the centre.

The inspector was satisfied that the location, design and layout of the premises were suited to its stated purpose and function and the needs of the residents.

There was evidence of good practice particularly in relation to facilitating and supporting effective communication; working collaboratively with families, risk management and supporting residents to live full and active lives.

All staff spoken with spoke respectfully of residents, their positive qualities and strengths and were clear on the supports required by each resident. The inspector observed that residents were relaxed in their environment and with staff.

However, there was one concerning finding in relation to actions taken in response to an incident of behaviour that challenged and this resulted in a major non-compliance Outcome 8: Safeguarding and safety. This finding was discussed in detail with the person in charge, the team leader and the regional manager as was the requirement for a robust and timely response to these matters. Of the remaining sixteen outcomes the provider was judged to be compliant in ten, substantially compliant with two and in moderate non-compliance with five.

The findings to support these judgements are in the body of the report; the action plan addressing the identified failings is found at the end of the report.
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:
Each support plan set out how each resident communicated their needs, choices and preferences. At times the support plan identified that this may be through a manifested behaviour; the behaviour, its meaning and the required response from staff was clearly recorded. Based on the inspectors own observations there was evidence that resident’s did exercise requests, choice and control and staff responded to residents in a timely manner. For example when a resident came to the office door at a particular time staff clearly understood that a specific activity was being requested; when another resident demonstrated some signs of anxiety staff quickly retrieved a required therapeutic intervention.

Consultation with residents and decision making by residents was also facilitated by the use of augmentative strategies such as PECS (picture exchange communication strategies). These enabled residents to communicate to staff what it was exactly that they wanted or did not want. This applied to the daily routine such as activities and meals or as situations evolved.

Each residents daily routine and preferences and how these were to be supported by staff were detailed in each support plan. Residents appeared to be relaxed in their environment and with staff and were seen to go about their daily routine as they largely determined such as seeking and getting the remote control for the television, accessing their preferred snack or choosing to stay with staff while they prepared meals.
However, while it was clear that residents did assert their choices and preferences the evidence to support consultation with residents rather than solely staff decision making in core areas was not strong particularly in relation to individual and weekly planners, setting goals and objectives and decisions in relation to medication management. How this could be enhanced was discussed with the PPIM.

There was a structured advocacy service available but staff said that on a day to day basis staff were expected to advocate for residents as necessary.

Residents had ready ongoing access to family as discussed again in Outcome 3.

With due regard to the nature of each resident’s disability staff accepted that two areas, spiritually and political rights needed to be explored further with some residents.

Staff were clear on the provider’s policy and procedures on the receipt and management of complaints. A complaint log was maintained and one complaint was recorded as received in 2015. While the complainant and the nature of the complaint were recorded, the actions taken in response, the feedback provided to the complainant and whether or not the complainant was satisfied were not.

Residents finances were managed with due regard for each resident’s individual capacity. Where staff supports were required staff maintained a financial ledger for each resident, transactions were recorded, daily balance checks by staff and a weekly balance check by the PPIM were completed. An audit of residents’ finances had been undertaken in November 2015 but the report was awaited. Based on a random sample of transactions reviewed by the inspector supporting receipts and staff signatures were in place. However, transactions were only ever verified by one staff and while this was as outlined in the providers policy, there were two staff on duty at all times. The requirement for two signatures for some if not all transactions would have enhanced the accountability and transparency of the existing policy and practice.

Judgment:
Substantially Compliant

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):
This was the centre’s first inspection by the Authority.
Findings:
All staff spoken with had a sound understanding of each resident’s communication requirements, the manner in which each resident communicated, its interpretation, the use of assistive technology and/or augmentative communication strategies. What staff relayed when spoken with, concurred with what the inspector saw in resident’s support plans and in practice. The assessment of each resident’s communication abilities and needs encompassed not only verbal communication skills but literacy, comprehension and understanding of language.

The inspector observed effective communication between staff and residents and was reassured that staff had a good understanding of how resident’s communicated their needs (at times through exhibited behaviours), be they physical, social or emotional; staff were seen to respond appropriately.

Effective communication was supported by augmentative strategies including manual sign language, choice boards, social stories, PECS (picture exchange communication strategies) and visual planners.

Residents had access to media and technology and through these mediums were seen to enjoy their favourite television programmes and music.

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

Findings:
There was evidence from staff, records seen and feedback received from families that services and supports were planned and provided in consultation with families and that residents were facilitated to enjoy ongoing family and personal relationships.

Families were consulted with and participated in the personal planning process and the review of the plan. Staff established the level and type of contact that each family requested and maintained a log of family contact.

Families confirmed their involvement and described the centre as a “positive environment” and staff as “respectful and supportive”. 

Staff said and the inspector saw that each resident enjoyed regular family contact and visits home; there was further evidence that families came to the centre in an unrestricted manner and as they wished. Staff confirmed that residents were supported through technology to maintain contact with family members who were not in a position to visit on a regular basis.

Staff said that some of the residents had progressed through the services together and all “got on” with each other. Contact with peers and the local community was supported through the day service, the residents’ involvement in activities such as swimming, horse-riding, the youth-club or attending the local shops, particularly those where a relationship with retail staff had been developed.

Staff confirmed that where residents had developed friendships with peers from other centres staff supported residents to maintain these friendships and this was structured into the weekly activity planner.

**Judgment:**
Compliant

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### 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):**
This was the centre’s first inspection by the Authority.

**Findings:**
There were policies and procedures governing admission to and discharge from the designated centre; the person in charge confirmed and the directory of residents reflected all admissions were referred through the statutory body.

Each resident had been provided with a contract for the provision of services and supports. The inspector was satisfied that these reflected individual requirements, were agreed and signed and set out the all of the fees to be charged.

**Judgment:**
Compliant
### 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:**

There was a process for assessing residents’ strengths and where additional supports were required from staff in core areas such as health, communication, independence and social integration. Both ability and the required supports were clearly set out in the support plan and the inspector was satisfied that what she observed and what staff said reflected the support plans.

There was documentary evidence that families as appropriate inputted into the planning process and participated in the annual review. With due regard to the nature of each resident’s disability, residents inputted directly into the compilation of their support plan. The predominately narrative personal plan was presented in a format that was accessible and meaningful to the resident; the inspector was satisfied that this plan based largely on photographic format reflected the narrative plan.

Personal goals and objectives, responsible persons and timeframes were identified. Goals and objectives seen had a developmental dimension and sought to support the resident in exploring new experiences. However, there was no clear link between the assessment, the support plans and the identified goals and objectives; in effect it was not clear how, when and by whom they had been identified. It was also difficult to ascertain from the available records if past identified goals were met or not, and if the review of the plan established if not why not. For example one identified goal in relation to communication, technology and PECS, had two expired timescales with no clear record as to why it had not been achieved within the agreed timeframes. A post-it was attached stating that it required updating.

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

Findings:
The inspector was satisfied that the location, design and layout of the premises were suited to its stated purpose and function. Overall, the premises was in good decorative order and notwithstanding some environmental restrictions was homely in presentation.

The premises was a domestic style two-storey building located in close proximity to local amenities. The premises included an annexed apartment with kitchen, living, bedroom and bathroom space for one resident.

Each resident had their own bedroom, rooms were seen to be of a suitable size and afforded the residents privacy and adequate personal storage. Two residents had en-suite sanitary facilities; two residents shared a bathroom with bath, shower, toilet and wash-hand basin that was in close proximity to their bedrooms.

Adequate communal space that also afforded choice was available to residents; adequate dining space was available. The kitchen though compact was sufficient and adequately equipped.

Facilities were available to support residents in the laundering of their personal clothing.

There was dedicated storage space and storage was not seen to present as a problem.

A secure garden with recreational equipment was available to the rear of the premises and was seen to be accessed by residents.

There were environmental restrictions and these are discussed in Outcome 8.

Judgment:
Compliant

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 inspector saw both an organisational and a local safety statement; both were in
date and incorporated the procedures for identifying and managing risk and accidents,
incidents and adverse events.

A comprehensive range of centre specific risk assessments were in place; controls and
responsible persons were identified and there was evidence that risks were reviewed
and where additional controls were required these were implemented. Controls were
required for resident safety and sought to balance resident independence with their
personal safety. At verbal feedback by way of recommendation the person in charge
was requested to review two specific risk assessments for the annexed apartment.

The risks specifically required by Regulation 26 (1) (c) were included in the risk register.

The inspector saw that the centre was serviced by an automated fire detection system,
manual fire-call points and emergency lighting; fire escape routes were clearly indicated
by illuminated signage. Certificates were available confirming that the fire detection
system, the emergency lighting and fire fighting equipment were tested and inspected
at the prescribed intervals and most recently in December 2015 and January 2016.

Staff undertook and recorded daily, weekly and monthly visual inspections of fire safety
measures.

Fire action notices, some in a format that reflected the needs of residents were
prominently displayed.

Records were maintained of staff attendance at fire prevention and management
training and these indicated that some staff had not attended training since 2014;
training had been provided in January 2016. Prior to the conclusion of the inspection the
person in charge confirmed that training for the outstanding staff was booked for the
10th and 17th February 2016.

Each resident had a personal emergency evacuation plan (PEEP) and simulated
evacuations were undertaken. However, records seen and staff confirmed that only
three such exercises had been undertaken in 2015; two of these were on consecutive
dates in April and none had been undertaken since June 2015. The inspector noted that
one simulated night-time evacuation exercise had taken over four minutes to complete
which is outside recommended evacuation times. There was no evidence of what actions
were taken to address this, for example the exercise had not been repeated under
similar circumstances and the particular difficulties encountered were not reflected in the
PEEPS.

There was a centre specific emergency plan that incorporated alternative
accommodation for residents if required. There was a risk assessment for and a recently
devised local procedure for responding to the unexplained absence of a resident from
the centre.

CCCTV was in use externally and monitored two rear doors; there was a policy in place governing the rationale for its use; security. However, it was brought to the attention of the person in charge that there was no signage in place and as required by data protection advising persons of its use.

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 measures in place to protect residents from harm and abuse. These measures included organisational and national policies and procedures, designated persons, risk assessments, staff training and education for residents as appropriate on self-protection. Staff said that there had been no incident of alleged, suspected or reported abuse.

However, staff training records indicated and the person in charge confirmed that two staff had no recorded attendance at training on safeguarding vulnerable adults.

The inspector saw that measures to promote and protect each resident’s privacy and dignity both in and outside of the centre, particularly where a resident may lack the awareness for same, was clearly outlined in residents’ support plans.

Training records indicated that staff had attended training in responding to behaviours that challenged. Risk assessments and detailed behaviour management guidelines that were specific to each resident were in place as appropriate. It was clear from these and from staff spoken with that staff interpreted behaviours as a form of communication, sought to understand and alleviate therapeutically any behaviour and its escalation.

Medication prescription and administration records indicated that there was minimal reliance on medication on a regular or PRN (as required) basis when managing behaviours that challenged or posed risk to the resident and others.
However, a review of what constituted a restrictive practice was required. Reasons for using restrictive practices, their monitoring, supervision and review were not clearly documented. There were policies and procedures in place defining and governing the use of restrictive practices. On visual inspection and based on records seen the inspector identified eight practices that reasonably could be described as restrictive; in line with the providers policy they had the potential to or did restrict resident(s) rights, freedom of movement and self determination. These included a locked downstairs toilet, restricted access to the kitchen and/or some foods, physical interventions to manage behaviour, an electronic locking system on the external doors. While there was some evidence in support plans that some of these restrictions may have been necessary to promote safety, only three practices (access to the kitchen and chemical restraint) had been very recently identified (29 January 2016) as restrictive with the required documentation submitted to the regional manager for review.

As stated above while there was evidence of good practice there was also evidence of very poor practice in relation to preventing and responding to behaviours that challenged.

It was recorded that an episode of challenging behaviour in late 2015 had escalated and resulted in an injury to staff. It was of serious concern to the inspector that a further unsigned and undated record pertaining to this incident seen by the inspector indicated that a punitive approach was taken in response to this incident. The documented response incorporated denial of a planned routine activity, and threats that cited a statutory body and the potential for action by that body. It was of further concern that the denied activity, a routine and right that the resident exercised to live independently was described as a “privilege”. When brought to the attention of the person in charge and PPIM they both said that they had no knowledge of this record or this approach to care and support of any resident. The person in charge confirmed with staff for the inspector the origin of the written record, confirmed that it was untrue that a report had been made to the statutory body, confirmed that the planned “privilege” had been cancelled, confirmed that the content of the record had been communicated to the resident in question. It was of further concern to the inspector that no staff member had questioned the approach taken, had not brought it to the attention of management and that there was a sufficient lack of oversight of supports and services to allow this to occur and go undetected. On further discussion with staff it was acknowledged that a possible trigger to the incident was known; the manner in which the resident had been communicated with on the day, yet it was the resident who was punished. This was discussed in detail during the inspection and again at verbal feedback with the regional manager. The provider was also advised that a robust and timely response to these matters was required to ensure that residents were at all times supported in line with best practice and protected at all times from all types of harm and abuse including untruths, threats and punishment.

**Judgment:**
Non Compliant - Major
### Outcome 09: Notification of Incidents

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

**Theme:**
Safe Services

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

**Findings:**
Records were maintained of accidents and incidents that occurred in the centre. There was documentary evidence that such events were reviewed by the person in charge and discussed on a routine basis with the regional manager and health and safety personnel. Based on the records seen the inspector was satisfied that notifications as required were submitted to the Chief Inspector.

**Judgment:**
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):**
This was the centre’s first inspection by the Authority.

**Findings:**
Each resident had access to structured day support services; some of these were facilitated on site but overall they were externally based. The day service was geographically removed from the centre but staff said that while this was not an ideal arrangement it did not present any particular challenges to residents as many of the individual activities facilitated by the day service were based locally.

Staff said and the inspector saw from support plans, individual planners and visual schedules that residents were supported to engage in a range of activities and individual pursuits that were of interest to them, that suited their individual skills and abilities and that they enjoyed. These activities included swimming, horse-riding, membership of the youth club, Special Olympics participation, athletics, art, personal grooming, shopping trips, cinema visits and part-time employment. Risk assessments and controls seen by the inspector indicated that staff sought to strike a positive balance between risk and
Resident participation. Records seen indicated that staff understood and respected resident’s choices to not engage in a particular activity.

**Judgment:**
Compliant

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**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:**
Staff reported that all of the residents enjoyed good physical health and were encouraged to make healthy living choices in relation to diet and exercise and social engagement; this was reflected in the support plans seen.

Staff said that residents in so far as was practicable attended the General Practitioner (GP) of their choosing and staff liaised with three different GP’s; all were described by staff as facilitative and supportive.

Staff said that as appropriate to individual needs residents had access to other health care services including psychiatry, psychology, occupational therapy, speech and language therapy, dental care and chiropody.

Staff said that in general they arranged and facilitated all required reviews and treatments but always in a collaborative manner with families.

Families surveyed confirmed that staff were “vigilant” in monitoring well-being and that resident’s health and well-being needs were regularly and adequately met. The inspector did see some healthcare related records that supported this and what staff said, but other healthcare records had been archived prior to the inspection and therefore were not available for the purposes of verification. This was discussed and the relevant action was issued under Outcome 18 Records and documentation.

**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:**
Staff had reported that residents enjoyed good physical health; this was reflected in the low incidence of prescribed medications.

There were policies and procedures governing medication management practices and staff spoken with confirmed that only staff who had successfully completed both medication management training and an assessment of competency administered medications.

Medications were seen to be securely stored and staff implemented other measures that enhanced safety including daily stock balance checks and signed, verified records of all medications supplied.

Medications were prescribed on a PRN (as required) basis as an adjunct to the management of behaviours that challenged but staff reported and records seen supported that they were not administered on a regular or routine basis.

There were procedures for the recording and investigation of medication errors; staff reported a low incidence of these and this would concur with records seen by the inspector. The inspector noted no anomalies between the prescription record, the administration record, the medications supplied and the affixed pharmacy label.

However, deficits were identified in that:
- the maximum dosage of all medications prescribed on a PRN basis was not stated
- one resident’s name was missing from the prescription record
- errors were noted in one protocol for the administration of a PRN medication.

Once brought to the attention of the person in charge these were all addressed during the course of the inspection.

No resident was taking responsibility for their own medication; on the basis of the overall inspection findings this was possibly a reasonable finding. It was discussed however with staff that an objective assessment of capacity would support and reflect consultation and participation with residents when making such decisions. This was discussed again in Outcome 1.

**Judgment:**
Compliant
### 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):**
This was the centre’s first inspection by the Authority.

**Findings:**
The statement of purpose contained all of the information required and reflected the centre and the supports and services provided to residents.

**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:**
There was a clear management structure in place consisting of the team leader (PPIM), the person in charge and the regional manager. All staff spoken with were clear on their respective roles, responsibilities and reporting relationships. Staff confirmed accessible and supportive working/reporting relationships.

The person in charge was employed on a full-time basis and had responsibility for two designated centres. The person in charge was suitably qualified for the role and held both nursing and management qualifications; the person in charge had established experience in the provision and supervision of healthcare and residential services. The person in charge understood and articulated responsibility for the service, the supports provided to residents and any failings identified.
On a day to day basis and when not present in this centre, the person in charge was supported in that role by the team leader, the nominated PPIM. The PPIM was suitably qualified and had established service with the provider and in the centre. The inspector was satisfied that the PPIM had a sound understanding of the PPIM role and responsibilities.

Staff said that they had ready access as required to the regional manager and opportunities for discussion, learning and peer support were facilitated through regular regional management meetings.

Staff confirmed that there was an on call out of hour’s manager available within the wider organisation; the rota was readily available to staff and seen by the inspector. The person in charge said that the on-call duty did not impact on the substantive role and responsibilities of the person in charge.

However, based on the failings identified in Outcome 8: Safeguarding and Safety and the fact that these particular failings were identified by inspection and not prior to that, the inspector was not satisfied that the management systems were sufficient to ensure that the supports provided to residents were safe, appropriate and consistently and effectively monitored.

There had been an unannounced visit to the centre to determine the safety and quality of care and supports and as required by Regulation 23 (2) (a) and (b) in October 2014. An annual review of the quality and safety of care and support in the centre as required by Regulation 23 (1) (d) had been undertaken on 27 January 2016; a report and action plan was available for inspection. The inspector was satisfied that this review was comprehensive and transparent; many of its findings reflected some of these inspection findings for example in relation to complaints, support plans, restrictive practices, staff supervision and training. However, while the review process demonstrated its capacity to be effective in monitoring both safety and quality this was compromised by the fact that the required reviews had not been undertaken at the required prescribed regulatory frequency.

**Judgment:**
Non Compliant - Moderate

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**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):**
This was the centre’s first inspection by the Authority.
### Findings:
Arrangements were in place for the management of the centre in the absence of the person in charge. In the absence of the person in charge the centre was managed by the team leader (the PPIM) with the support of the regional manager. The person in charge confirmed that there had been no absence of a duration that required notification to the Chief Inspector.

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

#### Findings:
Staff identified one resource barrier to supporting residents achieving their individual personal plans, suitable transportation. There was documentary evidence to support this in the form of professional review and recommendation that additional transport was required so as to enhance the range of available opportunities. The person in charge and the regional manager told the inspector that this matter had been identified and escalated.

#### Judgment:
Non Compliant - Moderate

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

#### Theme:
Responsive Workforce

#### Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.
Findings:
There was a planned rota devised by the PPIM and evidence that staffing was arranged to suit the number, needs and routines of the residents at any given time, that is if all residents were present or if some residents were on home leave and therefore less staff were required. Ordinarily Monday to Friday residents were not present in the house on a daily basis from approximately 09:00hrs to 15:00hrs. Generally staffing reflected a 1:1 staff/resident ratio. Night-time staffing consisted of one waking staff and one sleepover staff. There was no evidence that these staffing arrangements were not sufficient to meet the needs of the residents.

The person in charge confirmed that agency staff were employed and that there was a service level agreement in place. However, staff spoken with raised concerns in relation to the increasing use of agency staff. Staff articulated concerns as to the impact on residents, the residents’ capacity to manage change, the importance of consistency and routine to residents so as to maintain their well-being. Staff spoken with provided specific examples to the inspector to support their concerns. Staff confirmed that they had brought these specific concerns to the attention of management and that they were addressed, however, staff had ongoing concerns as to the increasing use of agency staff. The inspector reviewed the staff rota for the period from the 4 January 2016 to 7 February 2016 and saw that 27 shifts in this period were covered by eight different agency staff; over forty shifts in this same period were covered by six different relief staff.

Staff files were made available for the purposes of inspection. Only one file of the sample of files reviewed by the inspector fully satisfied regulatory requirements in that it contained all of the required documents. Missing documents across the remaining files included photographic identification in a format that was sufficient to verify identity, documentary evidence of core qualifications and a reference from the persons’ most recent employer.

Records were maintained of training completed by staff including mandatory training. The records indicated that there were gaps in staff attendance at training including fire, safeguarding vulnerable adults and medication management training and competency assessment. The PPIM confirmed that there were some inaccuracies in the records but there were also gaps in actual attendance. There was documentary evidence that prior to this inspection and in relation to these training gaps training in responding to behaviours that challenged, first aid, manual handling and medication management was scheduled to be completed before May 2016. Fire training for staff was booked prior to the completion of the inspection. A residual deficit in relation to training in safeguarding is addressed in Outcome 8.

There were formal systems for the supervision and support of staff. While their frequency is not prescribed by the Regulations, staff spoken with confirmed that they had not been undertaken in 2015 at the intervals required by the provider.

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

**Findings:**
There was documentary evidence that the provider had appropriate insurance in place.

There were policies that satisfied regulatory requirements and reflected the centre's practice.

The residents guide satisfied regulatory requirements and was available in a format that enhanced its accessibility and usefulness to residents.

A directory of residents was maintained and it included all of the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

However, staff confirmed that they archived records on an annual basis and in effect this meant that records required for the purposes of inspection to both satisfy and verify regulatory requirements were not all in place. These records included;

- the medical, nursing and psychiatric condition (where appropriate) of the resident at the time of admission
- all nursing or medical care, treatment or any other intervention provided to the resident
- on-going medical review, treatment and care
- all referrals and follow-up appointments.

**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:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by RehabCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002644</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>02 February 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>02 March 2016</td>
</tr>
</tbody>
</table>

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:
Two areas, spiritually and political rights needed to be explored further with some residents.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

**Please state the actions you have taken or are planning to take:**
- Service user in independent living apartment has been asked and has confirmed no interest in attending any religious service and this has been recorded in the support plan.
- A social story will be developed to give choice to two remaining service users regarding attending religious services and this has been recorded in their support plan.

**Proposed Timescale:** 13/03/2016
**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Financial transactions were only ever verified by one staff and while this was as outlined in the providers policy, the requirement for two signatures for some if not all transactions would have enhanced the accountability and transparency of the existing policy and practice.

2. **Action Required:**
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

**Please state the actions you have taken or are planning to take:**
- One service user has control of their own personal property and finances.
- When money is received from service user relatives a receipt is issued by the provider.
- When recording money received on service user finance sheet this will instead be verified by two members of staff by checking the copy of the receipt against money received, the two members of staff should then sign the service user finance sheet.
- Any spending over €20 will be verified by two members of staff when checking in the receipt, the balance should be checked and signed by the two members of staff.

**Proposed Timescale:** 24/02/2016
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The actions taken in response to a complaint, the feedback provided to the complainant and whether or not the complainant was satisfied were not recorded.
3. **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:**
- All complaints will be logged following the complaints process.
- All complaints will be responded to in a timely manner following the complaints process.
- All details of any investigation on foot of a complaint will be documented.
- Any outcome / action / feedback following the resolution of a complaint will be recorded.

**Proposed Timescale:** 24/02/2016

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**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no clear link between the assessment, the support plans and identified goals and objectives; in effect it was not clear how, when and by whom they had been identified. It was also difficult to ascertain from the available records if past identified goals were met or not, and if the review of the plan established if not why not.

4. **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:**
- Action plans to be updated to show pathway to achieving outcome, including any review, changes, variables, stakeholders involved.
- All planning recorded will give clear time scales and names of those responsible to achieve actions.
- Each change, review and recommendation will be recorded on the front sheet of the support plan.

**Proposed Timescale:** 18/03/2016
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:
Fire drills were not undertaken at suitable intervals. One simulated night-time evacuation exercise had taken over four minutes to complete which is outside recommended evacuation times. There was no evidence of what actions were taken to address this, for example the exercise had not been repeated under similar circumstances and the particular difficulties encountered were not reflected in the PEEPS.

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

Please state the actions you have taken or are planning to take:
• Fire drills will be carried out at least quarterly, in accordance with fire regulations.
• All actions required will be recorded with desired outcomes.
• All actions and desired outcomes will be reviewed and reflected in service user PEEPs.

Proposed Timescale: 24/02/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of what constituted a restrictive practice was required. Reasons for using restrictive practices, their monitoring, supervision and review were not clearly documented

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

Please state the actions you have taken or are planning to take:
• All outstanding restricted practices to be reviewed by restrictive practice committee.
• The review of all other suggested restricted practices to be assessed, following this all necessary actions and/or documentation pertaining to implementing a restrictive practice will be completed.

Proposed Timescale: 25/03/2016
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A punitive approach was taken in response to an incident of behaviour that challenged staff; the documented response incorporated denial of a planned routine activity, untruths and threats that cited a statutory body and the potential for action by that body. It was of further concern that the denied activity, a routine and right that the resident exercised to live independently was described as a “privilege”.

7. **Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
- Meeting held on the 8th February 2016 with staff involved in said incident. PIC advised that this was not a case of normal organisational or service practice, however, this was a reactive intervention made by an external professional hired by the organisation. This should be seen as a learning opportunity and that staff should feel confident to challenge any decision made by a professional / colleague / stakeholder; and that the organisation or service management would be supportive of that challenge if deemed appropriate. To be further discussed at next team meeting, scheduled for the 9th March 2016.
- Further intervention and support from external said professional postponed and then withdrawn with effect from the 10th February 2016.
- Meeting with new internal RehabCare professional on the 17th February 2016, ongoing support from same commencing 24th February 2016.
- Following a period of assessment of need by the said RehabCare professional, risk assessments and management guidelines to be reviewed and implemented in agreement with all stakeholders.
- New interventions are to be discussed with keyworkers, team leader and/or manager and will be documented in the appropriate format (support plan, risk assessment, management guidelines) and signed off prior to being implemented.
- Rehab Group Adult protection policy and procedure in place, read and signed as understood by all staff. All staff to be trained (2 staff remaining, date to be confirmed by training department). All staff and management to follow reporting process with any protection concerns.
- Safeguarding vulnerable adults procedure and process in place, read and signed as understood by all staff All staff and management to follow process with any safeguarding concerns.

**Proposed Timescale:** 31/03/2016
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training records indicated and the person in charge confirmed that two staff had no recorded attendance at training on safeguarding vulnerable adults.

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

Please state the actions you have taken or are planning to take:
• Three dates have been arranged in Tullamore on the 19th/20th/21st April 2016 and places have been booked for the two outstanding staff.

Proposed Timescale: 21/04/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Given the failings identified in Outcome 8: Safeguarding and Safety and the fact that these particular failings were identified by inspection and not prior to that, the inspector was not satisfied that the management systems were sufficient to ensure that the supports provided to residents were safe, appropriate and consistently and effectively monitored.

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

Please state the actions you have taken or are planning to take:
• New interventions are to be discussed with keyworkers, team leader and/or manager and will be documented in the appropriate format (support plan, risk assessment, behaviour management guidelines) and signed off prior to being implemented.
• Agenda item in the upcoming staff meeting on the 9th March 2016. Staff to feel confident to challenge a decision made by any stakeholder / professional / colleague in regards to a service users care.
• Rehab Group Adult protection policy and procedure in place, all staff to be trained (2 staff remaining, date to be confirmed by training department). All staff and management to follow reporting process with any protection concerns.
• Safeguarding vulnerable adults procedure and process in place. All staff and management to follow process with any safeguarding concerns.
**Proposed Timescale:** 09/03/2016  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The first annual review had been undertaken on 27 January 2016.

**10. 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:**  
- Staffing in quality and standards internal audit team has been increased to 15.
- Internal 18 outcome announced annual review visits will be made once a year.
- All future internal announced internal review visits will be completed in accordance with regulation 23 (2) (a)
- The centre is now compliant and structures are now being developed to ensure ongoing compliance.

**Proposed Timescale:** 02/03/2016  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
While the review process demonstrated its capacity to be effective in monitoring both safety and quality this was compromised by the fact that the required reviews had not been undertaken at the required prescribed regulatory frequency.

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

**Please state the actions you have taken or are planning to take:**  
- Unannounced review took place on 18th February 2016  
- Staffing in quality and standards internal audit team has been increased to 15.  
- All future internal unannounced visits will be completed in accordance with regulation 23 (2) (a)  
- The centre is now compliant and structures are now being developed to ensure ongoing compliance.

**Proposed Timescale:** 02/03/2016
### Outcome 16: Use of Resources

**Theme:** Use of Resources

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

There was one identified resource barrier; a requirement for additional transport.

#### 12. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

- As a short term solution transport issue was discussed with the regional manager and as a result temporary use of a lease vehicle was arranged and is ongoing.
- A permanent lease or purchased vehicle will be in place by 13th March 2016.

**Proposed Timescale:** 13/03/2016

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### Outcome 17: Workforce

**Theme:** Responsive Workforce

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

There was both an overreliance and lack of consistency in relation to the use of agency and relief staff,

#### 13. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

- Recruitment of two 25 hour positions has been commenced, expected completion to have staff in post following all pre-employment checks 29th April 2016.
- One full time member of staff returning from statutory leave in April 2016.
- Discussion with the staffing agency to develop a core group of staff that are familiar with the service.
- If there is a requirement to have a new agency careworker in, then this should only be as a last resort and careworker will be brought in prior to the shift for an induction or at least an hour before if in case of a late booking.

**Proposed Timescale:** 29/04/2016
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Only one file of the sample of files reviewed by the inspector fully satisfied regulatory requirements in that it contained all of the required documents.

**14. 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:**
- All documentation missing in the staff files as specified in Schedule 2 will be obtained for all staff.

- The human resources structures are now being developed to ensure ongoing compliance. An online system will be going live shortly, this will give managers access to all staff human resource documentation, this will help to ensure that all relevant documentation is in place before commencement in service.

**Proposed Timescale:** 25/03/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff confirmed that formal supervision had not taken place at the providers prescribed frequency.

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

**Please state the actions you have taken or are planning to take:**
- An annual supervision record was on view for supervisions that had taken place. This has now been updated with planned approximate dates for formal supervision to be held on a 6 weekly basis. Supervision will take place within one week of the planned date dependent on the rostered availability of the staff member receiving supervision.

**Proposed Timescale:** 17/02/2016
### Outcome 18: Records and documentation

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records were archived on an annual basis and in effect this meant that records relating to residents required for the purposes of inspection to both satisfy and verify regulatory requirements were not all in place

**16. 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:**
- All records from 2015 were requested back from our national archiving depot on the 16th February 2016. These were received on the 17th February 2016 and are now available for review.
- All reports for medical, psychological and other health were also requested back. These are now available in the service for review.

**Proposed Timescale:** 17/02/2016