## Health Information and Quality Authority

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St John of God Community Services Limited</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003647</td>
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<td>Centre county:</td>
<td>Louth</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<td>Registered provider:</td>
<td>St John of God Community Services Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Clare Dempsey</td>
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<tr>
<td>Lead inspector:</td>
<td>Anna Doyle</td>
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<td>Support inspector(s):</td>
<td></td>
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<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>7</td>
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<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
From: To:
20 April 2016 09:30 20 April 2016 19:30
21 April 2016 09:30 21 April 2016 17:00

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

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

Summary of findings from this inspection
Back ground to Inspection.
This was an 18 outcome inspection carried out to monitor compliance with the regulations and standards and to inform a registration decision. This was the second inspection carried out in the centre. The previous inspection was carried out in May 2014. At the time of the previous inspection the centre was part of a larger designated centre, however the provider has since reconfigured services and the centre is now a standalone centre. As part of this inspection, the action plan from the previous inspection was reviewed and the inspector found that all actions had been completed with the exception of one action. As part of the registration process, the
provider was requested to submit relevant documentation to the Health Information and Quality Authority (HIQA), however, some of the information was still outstanding.

How we gathered evidence
The inspection took place over two days. As part of the inspection, practices were observed and relevant documents were reviewed such as care plans, medical records, accident logs and staff files. One family member was spoken to on the first day of inspection. The inspector spoke with one resident and observed interactions between staff and residents as most residents were unable to tell the inspector about their views of the quality of the service. The inspector interviewed a number of staff including the clinical nurse manager (CNM) who was a person participating in management for this centre. The person in charge was present throughout the inspection but was not formally interviewed as part of this inspection as this had been completed at an earlier date by HIQA.

Description of the service
The provider had produced a document called the statement of purpose, as required by the regulations, which described the service provided. The inspector found that the service was being provided as it was described in that document. The designated centre is operated by St John of Gods North East Services and is situated in Co. Louth. It comprised of a large detached seven bedroom house located in the countryside not far from a small village. The property is currently being leased from a third party. Seven male residents reside in the centre which opened in 2013 as part of a move from a large institution.

Overall Findings
Overall, the inspector found that the provider had not taken adequate measures to ensure effective governance and management systems were in place in the centre. Major non-compliances were found in governance and management and health and safety. Moderate non-compliances were found in eight of the outcomes. They included: residents rights, contracts of care, social and health care needs, workforce, documentation, communication needs and medication management. The action plan at the end of this report identifies those areas where improvements were required in order to comply with the regulations and the HIQA standards.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Overall the inspector found that residents’ rights and dignity were maintained. However, improvements were required in relation to the management of complaints and residents rights in relation to their finances.

Residents were consulted about how the centre was run through residents' meetings that were held in the centre every week. The inspector viewed a sample of the minutes of these meetings and found that discussions took place around menu planning, health and safety, social activities and the recent national census form that had been delivered to the centre.

There was a complaints policy in the centre. There was evidence that the complaints procedure was discussed with family members at residents' annual review meetings. A number of complaints had been recorded in the centre and the inspector noted that some had been made by staff as advocates for the residents. The inspector saw evidence where these had been discussed at a residents meeting. However, it was not clear from the records how complaints had been followed up and whether the complainant was satisfied with the outcome. In addition, some complaints were recorded as unresolved. For example, a complaint had been made on behalf of a resident to have internet access in the centre so as they would be able to contact family members abroad. It was not clear what the actions taken had been to address this issue.

Staff members were observed to treat residents with dignity and respect. Residents had intimate care plans in place although some were not detailed enough to guide practice.
There was a policy in place on the management of residents’ finances; however, this had been due for review with in Oct 2015. The inspector viewed the financial records of one resident and found that effective safeguarding systems were in place. For example residents’ monies were checked daily by staff. In addition, the person in charge or the CNM checked residents’ bank statements against their financial records to ensure accuracy. The inspector was also informed that a new audit form was been implemented whereby the person in charge would check residents financial records stored in the centre.

Residents only had access to their finances through two staff members who were signatories on their account. One of whom was on long-term leave. This meant that only one staff member could access residents’ bank accounts. The inspector was informed that residents did not have access to bank cards to provide better access to their funds as this was a service policy, and only residents who had the ability to remember their personal identification number were allowed have bank cards. The inspector found that this was not respecting residents’ rights in terms of accessing finances.

**Judgment:**
Non Compliant - Moderate

### Outcome 02: Communication
*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
Overall, the inspector found that residents’ communication needs were, for the most part being met. However, improvements were required in residents’ communication plans in order to guide staff practice.

There was a policy in place for communication with residents and the inspector viewed some effective tools in place for residents' communication needs. For example, information for residents was in an accessible format including staff on duty, menu plans and activity schedules. In addition, residents had pain assessments completed in order to guide staff.

However, the communication plans in place were not detailed enough to guide staff. At the opening meeting the inspector was informed that the centre was in the process of completing communication assessments on all residents so as to guide the implementation of effective communication passports for all residents. Part of this
assessment would include whether residents would benefit from the use of electronic tablets in order to enhance their communication skills. The inspector found from reviewing residents' files that these improvements were required due to the communication needs of the residents. However, the inspector did observe staff interacting with residents and they appeared to have a very good understanding of residents’ communication styles.

Residents had access to television, radio and local newspapers. There was no internet access for residents in the centre. The inspector was informed that this was currently being addressed, however it had been noted in the complaints records that this issue had been ongoing since March 2015.

**Judgment:**
Non Compliant - Moderate

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

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
Overall the inspector found that positive relationships between family members and residents were supported and families were actively encouraged to visit the centre and be involved in the residents’ lives.

There were no restrictions on visitors to the centre in line with residents' own wishes. There was a local visitor’s policy in place confirming this. Residents had their own bedrooms and had access to areas in the centre where they could meet visitors in private.

One family member who met with the inspector spoke about their regular visits to the centre and how they were invited to the centre for Christmas dinner every year. Family members were invited to attend residents’ annual review meetings. The inspector saw evidence where annual reviews had taken place in locations near where residents' family members lived so as to ensure family members who may not have access to transport could attend. On the day of the inspection one of the residents was going out with a family member for the evening and another was visited by a family member.

Residents were supported to maintain links with their wider community. For example one resident was part of the local tidy towns committee.
Judgment:  
Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**  
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**  
Effective Services

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

**Findings:**  
Overall the inspector found that there was an admissions policy in place that included the transfer, discharge and temporary absence of residents in the centre. However, improvements were required in the contract of care for residents.

There were policies and procedures in place for admitting residents to the centre. Each resident had a contract of care and support. However, the section for the resident's representative signature on the contract had been signed by staff members and not by the resident's representatives where appropriate.

In addition the contracts of care did not describe the fees or additional fees that residents were charged. It also stated in the contract that residents may be charged for short breaks or holidays. When the inspector asked staff for clarification around this, staff were unsure what it meant.

There had been no new admissions to the centre since it opened in 2013.

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

Findings:
Overall the inspector found that residents had opportunities to participate in meaningful activities appropriate to their preferences. However, improvements were required in the assessment of need and the review of personal plans.

Each resident had a personal plan and the inspector viewed a sample of these. The personal plans were kept under regular review; however, some of the assessed needs were not fully implemented. For example one resident’s plan stated that they would benefit from swimming twice a week. The inspector found that this resident had not been swimming in the last number of months.

The inspector did see evidence in other residents' plans where they had goals set for the year, all of which had been completed. For example, one resident had been away for a night in a hotel, and had attended a sensory garden. Residents were also observed to be involved in activities in the centre in order to promote their independence; examples include cooking, doing their own laundry and assisting with household chores.

Each resident had a weekly activity plan in their personal plans. The inspector viewed a number of weekly activity plans for residents, and found that for the most part, residents were involved in varied activities. However, some activity schedules were not varied and activities were planned for very long periods of time. For example, one resident's weekly schedule included no activities for certain parts of the day and some activities were recorded to take place for three hour long sessions, for example, table top activities or water play which was not appropriate to the needs of the resident.

The inspector found that the review of residents' personal plans did not adequately assess the effectiveness of personal plans. For example, the inspector viewed one annual review for a resident. These reviews were called 'circle of support meetings' and family members were invited to attend. However, the inspector found that some of the information contained in the review was not detailed enough in order to review the effectiveness of the plan. For example, in one section the author was asked to comment on the number of incidents the resident had in the last year. The comment recorded stated to 'refer to the behaviour support plan'. There was no evidence of incidents contained in the behaviour support plan.

In addition one resident was learning to make a cup of tea independently. This had been broken down into simple steps for the resident to follow. Based on the assessment which had been carried out by staff, this process needed to be reviewed on a daily basis in order to assess its effectiveness and to support the resident. However the review process was not recorded daily and therefore it could not effectively review the progress this resident was making to achieve this goal.

Judgment:
Non Compliant - Moderate
### Outcome 06: Safe and suitable premises

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

#### Theme:
Effective Services

#### Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

#### Findings:
Overall the inspector found that the location and layout of the centre was suitable for its stated purpose and the action from the previous inspection had been completed. However, one area of the centre required attention.

The property was a large, modern two-storey detached house situated a short drive from the local village. The property was currently being leased from a third party, however, the person in charge informed the inspector that the service intended to purchase the property from the third party as the property was now up for sale.

Each resident had their own bedroom which had been personalised and ample storage room was available. All residents had locks on their bedroom doors. Four of the bedrooms were downstairs and the other bedrooms were located upstairs. There were adequate communal areas for residents to meet visitors in private.

There was a large kitchen-dining area with adequate cooking and storage facilities. However, the sink in the kitchen was worn and the paint/seal was eroded. The person in charge had contacted maintenance on the first day of the inspection and a date was scheduled for this work to be completed. Residents had access to a utility room and had the opportunity to launder their clothes on certain days if they wished.

There was a garden to the front and the rear of the property that was well maintained. The action from the previous inspection had been completed in that the walk-ways around the property had been addressed. The person in charge informed the inspector that additional maintenance work was to be completed to the driveway once there was confirmation that the service was purchasing the property.

There were systems in place for the disposal of clinical and general waste in the centre.

#### 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):**
No actions were required from the previous inspection.

**Findings:**
Overall the inspector found that in general the health and safety of residents, visitors and staff was promoted. However, improvements were required in residents’ risk management plans and fire evacuation procedures.

There was a risk management policy in place and the inspector saw evidence of environmental risks identified within the centre. Residents had individual risk assessments in place, where appropriate. However, not all of the control measures in place had been listed for one resident and one resident’s risk assessment did not give enough detail about the measures in place to reduce risks.

Incidents were recorded on a computer generated form and a copy was maintained in the centre. However, while the amount of incidents in the centre was recorded, there was no evidence that they were reviewed effectively to inform learning.

There were effective fire safety precautions in place. Suitable fire fighting equipment was provided throughout the centre and there was evidence that equipment had been serviced and checked appropriately. However, there was no illuminated fire exit signage at exit doors. The person in charge informed the inspector that this had been agreed as not being required with a fire consultant who had attended the centre. In addition, the centre had fire doors installed in the centre with the exception of three bedrooms upstairs. However, the person in charge had ordered these fire doors on the first day of the inspection.

A fire evacuation plan was displayed in a prominent area of the centre. However, there were two fire procedures in place and the inspector found that this did not guide practice. Each resident had a personal emergency egress plan (PEEP) in place. A sample was viewed and these were found to include information on mobility, awareness and supports needed.

The centre held fire drills and reports showed that the fire drills occurred at different times. However, issues identified had not been followed-up on. For example, one resident did not immediately leave the centre when a fire drill took place and needed to do one activity before evacuating the building. There was no evidence to support what actions had been taken to address this issue.

There were procedures in place for the prevention and control of infection. Adequate hand-washing facilities and sanitising hand gels were available in key areas throughout the centre. Daily cleaning schedules were in place.
The inspector found that the vehicle available in the centre had been serviced and had the necessary road worthiness certificate in place. However, the inspector found that the inside of the vehicle required some work. For example, there were areas rusted and worn. The inspector had been informed on the first day of the inspection that the vehicle was due to be changed, however on the second day of the inspection the person in charge stated that this was not going ahead.

**Judgment:**
Non Compliant - Major

### Outcome 08: Safeguarding and Safety

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

**Theme:**
Safe Services

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

**Findings:**
Overall the inspector found that there were measures in place to protect residents being harmed or suffering abuse. However, improvements were required in behaviour support plans.

The service had a policy on safeguarding vulnerable adults in the centre and staff were knowledgeable about what to do if an allegation of abuse was reported to them. The inspector saw evidence of additional good practices in relation to safeguarding residents in the centre. For example, all unexplained bruising was reported to the safeguarding committee in the service for review.

There was a policy in place for the provision of behaviour support and residents had access to support from a clinical nurse specialist in the service and psychology where appropriate. However, behaviour support plans did not always guide practice. For example, the inspector viewed one incident report for a resident who was displaying behaviours that challenge. It was indicated on the behaviour support plan that staff should rule out pain as part of the resident's supports, however there was no reference in the plan to the pain assessment tool in place for this resident. The inspector acknowledges that staff were able to tell the inspector how this resident demonstrated if they were in pain. However, there was no detailed guide contained in their behaviour support plan. In addition, one resident whose supports needs required that they had
daily checks completed in their rooms did not have any clear guidelines in place around how this should be done.

The inspector was informed that there were no restrictive practices in the centre.

**Judgment:**
Substantially Compliant

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

**Theme:**
Safe Services

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

**Findings:**
Overall the inspector found that a record of all incidents occurring in the designated centre were maintained and, where required, notified to HIQA.

**Judgment:**
Compliant

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**Outcome 10. General Welfare and Development**
*Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**
Health and Development

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

**Findings:**
Overall the inspector found that residents had opportunities for new experiences and social participation in their communities in line with their personal preferences.

Residents were involved in activities internal and external to the organisation. Residents did not attend a formal day service but did have access to day services on a sessional basis if they chose to.
Residents were seen to be involved in community activities and an activity planner was discussed at weekly residents' forum meetings.

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

**Findings:**
Overall the inspector found that residents' healthcare needs were being broadly met. However, improvements were required in healthcare assessments, health action plans and the implementation of allied health professionals’ recommendations.

The inspector viewed a sample of personal plans for residents and found that the assessment of need did not include all healthcare needs and some of the details contained in the assessment were duplicated or inconsistently recorded. For example, one resident's plan stated that they required some manual handling supports; however, elsewhere in the plan the resident was recorded as requiring no supports.

The inspector found that some health action plans did not include all details of care to be given. For example, one resident's epilepsy plan stated that oxygen should be administered; however, this resident was not prescribed this and according to staff did not require it in the event of a seizure. In addition, some assessed needs had no health action plans to guide practice. For example, some residents had no mental health action plans where this was indicated.

Residents had access to allied health professionals; however, in some instances recommendations had not been implemented. For example, one resident had a sensory assessment completed and the recommendations from this were not contained in the resident's personal plan.

The inspector observed some mealtimes at the inspection and found that residents had a nutritional and varied diet. There were pictorial menus available for residents. In addition meal preferences and specific nutritional needs were highlighted in residents' personal plans for those who could not communicate their preferences.
**Judgment:**
Non Compliant - Moderate

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

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

| Findings: |
| Overall the inspector found there were written operational policies relating to medication management in the centre; however, improvements were required in a number of areas. |

Residents' medications were dispensed from a local pharmacy into blister packs where appropriate and the inspector was informed that residents regularly accompanied staff to collect their medications and knew who their pharmacist was. The inspector found that medications were securely and appropriately stored in the centre and out-of-date or unused medications were stored separately from regular medications.

The inspector viewed a sample of medication prescription sheets and medication administration sheets (MAS) and found a number of areas required improvements. For example:
- Known allergies were not recorded on one resident’s prescription sheet.
- The times of administration were not clearly recorded on some prescription sheets. For example, one resident was prescribed medication once a week but it did not outline what day of the week this should be administered.
- The indications for the use of some PRN (as required) medications were not recorded on the prescription sheet. While this was recorded on a PRN protocol that had been signed by the resident’s GP, the inspector found that some of the information contained in the PRN protocol was inconsistent with the prescribed dose on the prescription sheet.
- One resident’s PRN medication had been discontinued, however, the inspector noted from this resident's personal plan that the last record from their psychiatrist had stated that the resident should remain on this medication. There was no clear explanation given from staff as to why this medication had been discontinued. The inspector was informed at the feedback meeting that this medication had been discontinued by the resident’s GP who was not the prescribing physician.
- The incorrect dosage was recorded for one medication and the incorrect time for another medication was recorded on the MAS sheet.

The discrepancies noted had been rectified by the last day of the inspection.

There were arrangements in place for the audit of medication management practices in the centre. For example, medication stock takes were completed weekly. However,
some of the medications stored were not part of this audit. For example, medications used for the management of epilepsy were not included. The inspector was also informed that a new three-monthly medication audit tool was to be introduced in the centre.

Medications that were sent home with residents were being dispensed into a separate pill box. This was not in line with best practice and the person in charge had discussed it with the pharmacist and found a solution to this before the end of the inspection.

**Judgment:**
Non Compliant - Moderate

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**Outcome 13: Statement of Purpose**

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

**Theme:**
Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Overall the inspector found that a written statement of purpose was available and that it broadly reflected the services provided in the centre. On review it was found that the document contained all of the information required in Schedule 1 of the regulations.

**Judgment:**
Compliant

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**Outcome 14: Governance and Management**

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

**Theme:**
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Overall the inspector found that improvements were required to ensure effective governance and management systems were in place in the centre.

The person in charge had significant experience and training and was very knowledgeable of the regulations and the residents’ needs in the centre. However, the person in charge was responsible for six designated centres, all of which were located approximately 20 kilometres away from each other. This meant that the person in charge was only available to the centre for approximately six hours a week. While the person in charge was supported in their role by another manager in the centre, this manager was also responsible for another designated centre and was therefore not full-time in this centre. The inspector was not satisfied that this arrangement was effective so as to promote and support the delivery of safe, quality care services.

The inspector found that two unannounced quality visits had taken place in the centre. The actions from these were formulated in a quality enhancement plan for the centre. However, these plans included findings from a number of different audits carried out in the centre and it was not possible to assess whether or not the actions from the quality audits had been completed. Therefore it was not evident that these activities had led to an improvement in the quality and safety of care provided.

The annual report was not yet compiled but the inspector was informed that a template and procedure for undertaking this was in development.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
Overall the inspector found that there were satisfactory arrangements in place to cover any absences of the person in charge.
The provider was aware of the requirements to notify HIQA in the event of the person in charge being absent and HIQA had been notified of any absence for more than 28 days.

**Judgment:**
Compliant

### Outcome 16: Use of Resources
*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**
Use of Resources

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

**Findings:**
Overall the inspector found that there were enough resources to support residents in achieving their individual personal plans in the centre.

Staff spoken to felt that there was adequate resources in place to meet residents’ needs and informed the inspector that additional staffing could be organised for activities outside the centre as required in order to provide more individualised supports.

**Judgment:**
Compliant

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

**Theme:**
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
Overall the inspector found that there were appropriate staff numbers and skills mix to meet the assessed needs of the residents, however improvements were required in staff files and staff training.

The inspector met with a number of staff over the course of the inspection and found them to be knowledgeable of residents’ needs. Staff stated that they felt supported in their roles and could raise concerns with the person in charge through supervision and staff meetings.

Regular staff meetings were held in the centre and the inspector viewed a sample of minutes from supervision meetings and performance development reviews that had been completed with staff. While the inspector found that a range of issues were discussed, including training needs, there was no action plans identified so as to ensure that issues raised were been followed up.

All staff had completed mandatory training in manual handling and safeguarding vulnerable adults. However, one staff member had not completed refresher training in fire safety and some staff had not completed training in the management of behaviour that challenges and the management of dysphagia in order to meet the assessed needs of residents. In addition, risk management training had not been completed for all staff. This had been an action from the previous inspection.

Regular relief staff were used where possible to promote consistency of care for residents. Agency staff were employed from time-to-time in the centre, however there was no evidence on the day of the inspection to show that agency staff were trained in safeguarding vulnerable adults and fire safety. This was discussed at the feedback meeting. Evidence of training was submitted to HIQA following the inspection which confirmed that agency staff were required to complete mandatory training.

The inspector reviewed a sample of staff files and found that for the most part these were in line with the regulations; however, one staff file contained a gap in their employment history. This information had been submitted to HIQA after the inspection.

The inspector was informed that there were no volunteers employed in the centre at the time of the inspection.

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):**

No actions were required from the previous inspection.

**Findings:**

Overall the inspector found that most of the documentation required by the regulations was maintained in the centre; however, some improvements were required to ensure that all of the policies and procedures as per Schedule 5 of the regulations were in place.

Residents’ records were safely stored in the centre and were available to the inspector. However, gaps were evident in some of the personal plans and some of the information contained in the plans was duplicated.

The policies and procedures outlined in Schedule 5 of the regulations were not all available in the centre. This included:
- The provision of intimate care had not been reviewed in 2011 as per the policy.
- The provision of behaviour support was in draft format.
- The policy on access to education, training and development was in draft format.

An up-to-date insurance policy was in place for the centre which included cover for residents’ personal property and accident and injury to residents in compliance with all the requirements.

The information required under Regulation 21 and listed in Schedule 4 was maintained in the centre.

A resident’s guide and directory of residents was maintained which included all the required information.

**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:

Anna Doyle  
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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St John of God Community Services Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003647</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>20 April 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>16 June 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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents had limited access to their finances as there was only one person authorised to withdraw funds from residents' accounts.

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 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:**
1. A second staff member is presently on the roster within this House who can support resident’s access their finances in a timely manner. 5th May 2016
2. The Finance Policy has been amended to reflect the needs of the resident to access their finance. 30th August 2016
3. All residents will be support to obtained bank cards to access their finances. 30th August 2016

**Proposed Timescale:** 30/08/2016

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not clear from the complaints records if the complainant was satisfied with the outcome of the complaint.

2. **Action Required:**
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

**Please state the actions you have taken or are planning to take:**
1. All complaints will be reviewed and satisfaction with the outcome will be added to the complaints documents and logging form within this House. 30th June 2016
2. All staff will be inducted into this new process by House Manager. 14th July 2016

**Proposed Timescale:**

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the complaints were recorded as being unresolved in the complaints log.

One complaint did not detail the actions that were taken to address the concern raised.

3. **Action Required:**
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.
Please state the actions you have taken or are planning to take:
1. A review has taken place of all outstanding complaints in the complaint Folder and they have all being brought to conclusion with the exception of two. 20th June 2016
2. The Senior Management of the Service are looking to replace the existing bus with a purchase of a suitable vehicle. 30th September 2016
3. The Senior Management Team is in the process of stabilising the tenancy arrangement with regard to this Designated Centre following the appropriate processes. 31st December 2016

**Proposed Timescale:** 30/12/2016

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**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The communication plans in place were not detailed enough to guide practice.

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

Please state the actions you have taken or are planning to take:
1. Referrals to be made to speech and language therapists for residents who require same. 7th June 2016
2. Recommendation from the assessments will then be put into place. 30th September 2016

**Proposed Timescale:** 30/08/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no internet access for residents in the centre. This issue had been raised through the complaints process.

**5. Action Required:**
Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

Please state the actions you have taken or are planning to take:
1. Wifi to be discussed at resident’s weekly House meeting. 11th June 2016
2. Advocacy supports will be put in place for residents as required. 31st July 2016
3. Residents will be supported to purchase their own WiFi access as required and the cost of same will be reflected in the contract of care. 31st August 2016
4. A Corporate Committee has been established to agree guidelines around the provision of Public WiFi access for residents and the recommendation of this Committee will be implemented. 30th November 2016

**Proposed Timescale:** 30/11/2016

### Outcome 04: Admissions and Contract for the Provision of Services

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The contracts of care and support had not been signed by the residents' representatives where appropriate.

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

**Please state the actions you have taken or are planning to take:**
Contracts of care will be posted out to all next of kin who have not yet signed the contract.

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The contracts of care in place for residents did not outline the fees to be charged and any additional fees that may be incurred.

The contract of care did not fully explain what costs residents would incur if they had to pay for short breaks/holidays.

7. **Action Required:**
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

**Please state the actions you have taken or are planning to take:**
The contract of care will be amended to include all expenses that the resident will incur. This will include short breaks & holidays. The cost of the holiday will be divided equally
among the residents participation in the break including the cost of staff accommodation only.

**Proposed Timescale:** 20/06/2016

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
One residents' assessed social care needs had not been implemented.

Activity schedules for one resident were not varied so as to meet the residents assessed needs.

8. **Action Required:**
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
1. The Activity schedules will now include residents preferred individual needs. 18th June 2016
2. All residents goals will be reviewed and recorded in their Individual Programme Plan. 30th June 2016

**Proposed Timescale:** 30/06/2016

| Theme: Effective Services |

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The review process was not recorded in sufficient detail for a resident who was learning a new skill.

The annual review did not contain enough detail so as to review the effectiveness of the personal plan.

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

**Please state the actions you have taken or are planning to take:**
1. The skills teaching programme has been reviewed and broken into steps with a review section on tasks completed.
2. The circle of support meeting for two residents which were outstanding on the day of inspection will take place by the 31st August 2016. The Circle of support meeting
The inside of the vehicle required some work as outlined in the report.

10. **Action Required:**
Under Regulation 26 (3) you are required to: Ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

Please state the actions you have taken or are planning to take:
The Senior Management of the Service are looking to replace the existing bus with a purchase of a suitable vehicle.

**Proposed Timescale:** 30/09/2016

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents individual risk assessments did not include all control measures in place.

Incidents within the centre were not effectively reviewed.

11. **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. All control measures contained within the risk assessments for residents are now in place.
2. One residents risk assessment has been updated to include additional measures in place to reduce risks.
3. A monthly report is generated and all Incidents are reviewed monthly from this report and Actions and learning developed. An immediate review takes place if a Moderate / Major incident occurs

**Proposed Timescale:** 24/04/2016
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Three bedrooms upstairs did not have fire doors in place.

12. **Action Required:**
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
Fire doors have been installed on the three bedroom upstairs

**Proposed Timescale:** 03/06/2016

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no follow up to issues identified for one resident during a fire drill.

There were two fire evacuation procedures in the centre.

13. **Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**
1. Additional measures were put in place for the one resident who had issues when evacuating the building. 4th June 2016
2. This resident’s personal evacuation plan has been updated to include this. 4th June 2016
3. While 2 fire evacuation drills had taken place so far in 2016 and a further night drill scheduled for 27th June 2016 and two further day time fire drills scheduled for 19th August and 1st November. All actions arising from these drills will be implemented.
4. There is one fire evacuation procedure in place within the centre and all staff are inducted on this. 4th June 2016

**Proposed Timescale:** 01/11/2016
## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some behaviour support plans were not detailed enough to guide practice.

### 14. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**
1. All behaviour support plans for residents will be reviewed and up dated to ensure they guide best practice. 30th June 2016
2. All staff have been inducted into the revised Behaviour Support plans. 8th July 2016.

**Proposed Timescale:** 08/07/2016

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## Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The assessment of need did not include all healthcare needs.

Health action plans did not include all details of care to be given.

Some assessed needs had no health action plans to guide practice.

### 15. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**
1. All Residents Health Assessments are being reviewed and actions plans updated. 31st July 2016
2. The resident’s plan which stated that they required some manual handling supports has been amended as this resident does not require manual handling support. 4th June 2016
3. The resident’s epilepsy plan has been amended to reflect the care needs required while experiencing a seizure. 4th June 2016
4. All resident have had a full review by the Consultant Psychiatrist and all care plans have been reviewed to reflect this consult. 8th June 2016
5. The residents sensory assessment has been incorporated into his care plan. 30th June 2016

**Proposed Timescale:** 31/07/2016
### Theme: Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
An assessment completed by an allied health professional was not evident on one resident's personal plan.

<table>
<thead>
<tr>
<th>16. <strong>Action Required:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.</td>
</tr>
</tbody>
</table>

**Please state the actions you have taken or are planning to take:**
The resident's sensory assessment has been incorporated into his care plan.

**Proposed Timescale:** 30/06/2016

### Outcome 12. Medication Management

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Known allergies were not recorded on one resident's prescription sheet.

- The times of administration were not clearly recorded on some prescription sheets.
- The indications for the use of some PRN (as required) medications were not recorded on the prescription sheet.
- One resident's PRN medication had been discontinued and staff were unaware why this was discontinued.
- The incorrect dosage was recorded for one medication.
- The incorrect time for another medication was recorded on the MAS sheet.

<table>
<thead>
<tr>
<th>17. <strong>Action Required:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.</td>
</tr>
</tbody>
</table>

**Please state the actions you have taken or are planning to take:**
1. All residents known Allergies are on the Kardex
2. All times of Medication is clearly recorded on the Prescriptions
3. All PRN indications are clearly recorded on the prescription
4. The resident who had his PRN discontinued was reviewed by the consultant
Psychiatrist
5. MARS sheet has been amended by Pharmacist to reflect the correct dose
6. The times on the MARs sheet have been amended

**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:**
The person in charge manages six designated centres and cannot ensure effective governance for this centre.

18. **Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
The Person in Charge's areas of responsibility have been reviewed and reduced to ensure effective governance of this Designated Centre. This is a reduction of 5 houses and one complete designated centre.

**Proposed Timescale:** 13/06/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence to support if findings from the unannounced quality reviews completed in the centre had been addressed.

19. **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:**
The quality enhancement plan for this Designated Centre has been reviewed to reflect evidence that all findings from the unannounced quality reviews have been addressed.

**Proposed Timescale:** 16/06/2016
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review completed for the centre.

20. **Action Required:**
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

**Please state the actions you have taken or are planning to take:**
1. The annual review will be completed for the Designated Centre. 30th June 2016
2. All recommendations will be reviewed and implemented for this Designated Centre. 30th September 2016

**Proposed Timescale:**

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**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 had not completed refresher training in fire safety.

Not all staff were trained in the management of challenging behaviour and the management of dysphagia.

Risk management training had not been implemented for all staff.

21. **Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**
1. Staff have now completed refresher fire safety training. 30th June 2016
2. All staff will get training in positive behaviour support. 30th June 2016
3. All staff will receive training in Dysphagia. 26th June 2016
4. Risk management training will be given to all staff. 31st July 2016

**Proposed Timescale:** 31/07/2016
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no action plans identified so as to ensure that issues raised at supervision meetings were been followed up and completed.

22. **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:
Action plans are now in place following supervision meetings and follow up is taking place.

**Proposed Timescale:** 30/06/2016

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**Outcome 18: Records and documentation**

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the policies as outlined in the report were not available in the centre.

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

Please state the actions you have taken or are planning to take:
All policies are now in the centre.

**Proposed Timescale:** 30/04/2016

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Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' personal plans had gaps in the records maintained and some of the information was duplicated and did not contain the same information in the duplicated documents.

24. **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.
<table>
<thead>
<tr>
<th><strong>Please state the actions you have taken or are planning to take:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Individual Personnel plans have been reviewed and gaps in records have been addressed. Alongside this information duplicated within resident’s files has been addressed.</td>
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| **Proposed Timescale:** | 15/07/2016 |