Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0004136
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Naoise Hughes
Lead inspector:	Anna Doyle
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	14
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
10 March 2016 10:00	10 March 2016 20:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first inspection of this centre by the Health Information and Quality Authority (the Authority). The inspection was unannounced and the purpose of the inspection was to assess the level of compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013 and the standard of care delivered to residents in the facility.

This centre forms part of St John of God's Carmona services, a large service provider to persons with disabilities and is considered to meet the criteria for registration as a designated centre under the Health Act 2007. As part of the inspection process the inspector met with the person in charge, staff, and residents. Inspectors observed practices and reviewed documentation such as health care records, risk management and medication management systems.

The centre comprises of three community houses situated in close proximity to each other in south county Dublin. The service is available to male and female adults. There is access to local community facilities and public transport services. The person in charge was present on the morning of the inspection. They attended the feedback meeting along with the service manager and the provider nominee.

Overall inspectors found evidence of good practices in the centre. Residents appeared happy living in the centre and staff were observed to treat residents with dignity and respect during the inspection. However significant improvements were required in fire safety and workforce. Other areas of improvement included risk management, safeguarding, healthcare needs and social care needs. The action plan at the end of this report outlines the areas that need to be addressed.

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 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:
Over inspectors found that each resident had a written personal plan that detailed their individual needs and choices. However improvements were required in the arrangements in place to meet the assessed social care needs of residents in one area of the centre.

Inspectors reviewed a sample of personal plans and found that for the most part residents participated in meaningful activities that were in line with their interests. Each resident attended a day service and there was evidence in residents' plans of the activities that they participated in, within the day service. In addition inspectors saw evidence of where residents attended activities in the evening times and at weekends this included bowling, drama classes and meals out in the community. However in one area of the centre the opportunities available to residents in the evening time were limited due to insufficient staffing levels.

Residents' plans were in an accessible format and an annual review had been completed in consultation with the resident and their family members. Goals for the year were developed from this. A review process was in place in the form of personal outcome measures, however there was no system in place to record and review independent living skills teaching. For example one resident was learning how to shave independently. There was no documentation within their plan that detailed how this skill was to be taught and how to review the effectiveness of this goal.

Judgment:
Substantially 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:
Overall inspectors found the health and safety of residents, visitors and staff was promoted and protected. However, improvements were required in relation to fire precautions, reviewing incidents and risk management in the centre.

There were policies and procedures relating to health and safety and an up to date health and safety statement was available. Procedures were in place for the prevention and control of infection, for example, inspectors observed personal protective equipment available throughout the centre, there were suitable hand washing facilities throughout the centre and colour coded mops and buckets were available. Colour coded chopping boards were available and the inspectors found the kitchen and dining area clean and otherwise well maintained. There was a cleaning schedule in place outlining the duties to be completed in the centre.

The centre had a risk management policy in place and site specific risk assessments were available detailing the risk and control measures in place to reduce the risk in areas such as manual handling, medication, infection control, missing persons and food safety. However, some improvements were required in this area as some risk assessments in place were unclear regarding the control measures. For example a risk assessment for 'use of electrical equipment' was describing the controls in place for fire and the risk assessment for 'household equipment' described the controls in place to manage slips, trips and falls.

Individual risk assessments were in place for some residents for risks such as dysphagia. However, some did not identify all risks for example there was no risk assessments for aggression and violence and accidental injury to residents, visitors and staff.

Inspectors found the procedures relating to emergency planning contained the details of the location to where the residents would be evacuated to or the arrangements for alternative accommodation should this be required.

There were adequate precautions against the risk of fire in place. However, there were no fire doors installed in the centre. The person in charge noted that this had been identified and was in the process of being addressed. The fire evacuation plan was prominently displayed. Personal emergency evacuation plans (PEEP) were in place for all

residents. However one resident's PEEP had not been reviewed in line with their changing needs. All fire exits were unobstructed on the day of inspection and staff had received training on fire safety. Fire drills were carried out regularly in the centre and reports showed that the fire drills occurred at different times. The fire drill records recorded the time taken to evacuate and issues identified. Suitable fire equipment was provided including a fire alarm, emergency lighting and fire extinguishers. All fire equipment had been serviced within the last year.

Inspectors reviewed records of incidents occurring in the centre and found there to be suitable follow up in the majority of incidents, however, this was inconsistent. For example in follow up to an incident regarding road safety for one resident, the centre was to develop a social story but this was not in place at the time of inspection. In addition there was no formal system for identifying trends and learning from all incidents and accidents in the centre.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Overall inspectors found that measures were in place to protect residents from being harmed or suffering abuse. However improvements were required in the implementation of safeguarding measures to protect all residents.

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. Inspectors 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.

However the safeguarding plan in place within one house to reduce the occurrence of difficult behaviour could not be implemented due to inadequate staffing levels. For example as part of the safeguarding plan, staff were required to provide specific support

and activities to a resident. However three other residents lived in the centre and this staff member was responsible for ensuring that their needs were met, while also ensuring that meals were prepared and other household tasks were completed. Inspectors observed interactions/practices and found that one staff member could not adequately supervise and support all residents while also ensuring that safeguarding measures were adequately implemented. The inspectors reviewed the rosters and activity schedules for the resident which confirmed that one staff member was on duty on many evenings. Inspectors spoke to the person in charge regarding this on the day of the inspection and asked for additional staffing to be employed to ensure that residents safeguarding needs could be met. The person in charge dealt with this appropriately.

Residents had behaviour support plans in place and of the sample viewed were found to be detailed enough to guide staff practice.

The person in charge informed inspectors of one restrictive practice been used in the centre. However this was regularly reviewed and was used as a safety precaution. The resident could put the restraint on themselves and take it off when required.

Staff were observed to be respectful of residents and intimate care plans were in place. However aspects of the plans were not detailed enough to guide practice. For example some plans stated that a resident required support, but it did not detail what the supports were.

Judgment:
Non Compliant - Moderate

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:
Overall inspectors found that residents were supported to achieve best possible health. However improvements were required in the assessment of need and health action plans.

Inspectors reviewed a sample of residents' personal plans and found that a detailed assessment of need had been completed that was in a user friendly format. There was evidence that this had been completed in consultation with family members and residents. However some health care needs had not been highlighted in the assessment

and there were no health action plans in place to guide staff practice. For example one resident had no health action plan for hypothyroidism. In addition there were gaps in records maintained. For example some documents were not signed by the relevant people and one residents follow up appointment with the GP from Jan 2016 had not been documented. Inspectors acknowledge that the staff member was able to tell the inspectors what the follow up was and confirmed this with the resident's GP on the day of the inspection.

Residents had access to allied health professionals as required and inspectors saw evidence of a multi disciplinary team meeting that had recently been held due to the changing needs of one resident.

Residents' meals were not observed by inspectors; however inspectors did observe residents participating in preparing the evening meal with staff. Food available was varied and nutritious and inspectors reviewed a number of menu plans that provided evidence of this. The advice of dieticians and speech and language therapists were available in a user friendly format for residents who required it. Staff were knowledgeable about the individual needs of these residents and the supervision required during meal times.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Overall inspectors found that while there were policies and procedures in place for the safe administration of medication, improvements were required in the disposal of unused medications, the storage of medications in the centre and prescribing practices.

There was a service policy on the safe administration of medication maintained in the centre. Staff spoken to were knowledgeable about medication practices and the training records showed that all staff were trained in the safe administration of medication.

Medications were delivered to the centre from a local pharmacy and were dispensed in 'blister packs'. There was a system in place to ensure that records were maintained of all medications stored in the centre. However records of unused or discontinued medications were not fully maintained and there was no clear local policy in place to

guide practice. In addition the storage facilities were not adequate for all the medications stored in the centre.

Inspectors viewed a sample of medication administration sheets (MAS) and found that for the most part they were in line with best practice. However one PRN (as required medication) did not have the indications for use recorded.

The pharmacist along with the social care leader completed an audit on medications in the centre every six months. Inspectors viewed one of these audits and found that there was no system in place to record whether these actions had been completed and who was responsible for them.

Inspectors viewed the medication errors that had occurred in the centre and found that errors were followed up with individual members of staff when they occurred so as to inform future learning.

Residents had individual medication management plans in place that were in a user friendly format. They were signed where possible by the resident. All residents were assessed yearly regarding self administration of medications in the centre.

There were no controlled drugs maintained in the centre and from the sample of MAS's viewed there was no chemical restraint prescribed for residents.

Judgment:
Substantially 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:
Overall inspectors found that the quality of care and experience of residents was been monitored in the centre. However improvements were required in the annual review for the centre.

Inspectors found that effective management systems were in place. The person in charge reported to a service manager who in turn reported to provider nominee.

The person in charge was responsible for other areas in the service; however they were supported by a social care leader who is a PPIM for the centre. This person was on leave on the day of the inspection. Inspectors saw evidence of regular meetings between the person in charge and the social care leader. In addition weekly staff meetings were held. Inspectors reviewed a sample of these and found them to be detailed but there were gaps evident in the records and it was not clear who was responsible for the actions identified from the meeting.

Unannounced six monthly reviews had been completed in the centre. In addition the annual review had been completed and while this had been developed into a user friendly format for residents, it was not clear whether residents or family members had been involved in this review.

The person in charge was not formally interviewed as part of this inspection.

Judgment:
Substantially Compliant

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found that there was a skill mix appropriate to residents needs. However improvements were required in staffing levels in the centre.

The staffing levels in the centre were not in line with the statement of purpose. For example according to the statement of purpose all areas in the centre had a staffing compliment of four staff. However when inspectors reviewed staff rotas in one area of the centre only three fulltime staff were rostered. The fourth staff who was on extended leave had not been replaced and additional staffing was being provided by relief staff. This led to an over reliance on relief staff in the centre. In addition the staffing levels in the centre were not consistent. For example staff informed inspectors that two staff should be on duty in the evening times in one area of the centre during the week. When

inspectors reviewed rosters it was found that two staff were only available one evening during the week. In addition inspectors were informed that this additional staffing could be relocated to other parts of the centre at short notice. This was confirmed in the minutes of a meeting held between the person in charge and the social care leader, read by inspectors. Inspectors reviewed a sample of activity schedules for residents in this area of the centre and found that some weeks residents had very little participation in evening activities outside the centre. For example one resident had no evening activities outside the centre and others had a walk to the shops once a week or went for coffee with a volunteer. In addition inspectors found that the staffing levels in the centre contributed to the findings in Outcome 8 of this report.

Staff interviewed felt supported in their roles. Supervision meeting were taking place in the centre and all staff had an annual performance appraisal completed.

All staff had completed mandatory training as required. Inspectors reviewed a sample of personnel files and found that for the most part they were in line with the requirements set out in Schedule 2 of the regulations. However some gaps were evident in the employment history for some staff.

Volunteers were employed in the centre and inspectors reviewed their files. The necessary documentation was found to be in place and volunteers had their roles and responsibilities set out.

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[1]

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0004136
Date of Inspection:	10 March 2016
Date of response:	19/04/2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 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 system in place to record and review the effectiveness of goals that had been identified for 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 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
A. Personal Outcome Measures interview and planning meeting will be completed annually with a quarterly review of goals by the Keyworker. 31/07/2016

B. Independent living skill goals will be identified through Personal Outcome Measures, Using Your Environment Assessment and keyworker meetings with a minimum of a quarterly review of goals by the Keyworker. The progress in relation to each goal will be documented. 31/07/2016

Proposed Timescale: 31/07/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
Some risk assessments were unclear on the risk being controlled.

Not all individual risks were identified.

There was no formal system for investigating and learning from all incidents and accidents evident.

Not all incidents were followed up appropriately.

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

Please state the actions you have taken or are planning to take:
A. All risk assessments will be reviewed to ensure the risk is clearly identified. 31/05/2016

B. Each individual risk will be identified with control measures detailed per individual risk. 31/05/2016

C. Each incident will be investigated at a house level, learning from the incident will be identified and control measures detailed. 31/05/2016

D. The Person in Charge and Social Care Leader will review the incidents on a monthly basis to ensure an effective investigation and to identify learning and trends in the

Designated Centre. 30/04/2016

E. Each incident will be reviewed following the incident to ensure the control measures identified at time of incident have been implemented and to ascertain their effectiveness. 30/04/2016

Proposed Timescale: 31/05/2016

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
There were no fire doors in place in the centre.

3. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
Where fire doors are required they will be installed within the Designated Centre.

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident's personal emergency evacuation plan had not reviewed in line with their changing needs.

4. Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
Social Care Leader and Keyworkers will review personal evacuation plans to ensure they reflect residents current support needs and will ensure the personal evacuation plans are reviewed on an on-going basis in line with changing needs.

Proposed Timescale: 19/05/2016

Outcome 08: Safeguarding and Safety
Theme: Safe Services **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The safeguarding plan in place could not be fully implemented due to inadequate staffing levels in the centre. **5. Action Required:** Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse. **Please state the actions you have taken or are planning to take:** The staff numbers in one area of the Designated Centre have been reviewed. With immediate effect on an interim basis additional staffing has been provided in one house to allow for double cover in the evenings (Monday to Thursday) when all ladies are in the house. This will facilitate the implementation of the safe guarding plan in the house. Further to this a full review of all 3 rosters within the DC will be conducted in consultation with staff in order to meet the assessed needs of the residents.
Proposed Timescale: 02/09/2016
Theme: Safe Services **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Intimate care plans were not detailed enough to guide practice, so as to ensure a residents privacy and dignity was maintained. **6. Action Required:** Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity. **Please state the actions you have taken or are planning to take:** Social Care Leader and Keyworker will review each intimate care plan to ensure they are sufficiently detailed to guide staff practice.
Proposed Timescale: 30/06/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some healthcare needs were not recorded in the assessment of need contained in residents' personal plans.

There were no health action plans in place to guide staff practice.

There were gaps in records maintained in personal plans and there was no documentation to support that one residents healthcare concern had been followed up.

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

Please state the actions you have taken or are planning to take:
A. The health assessment (forming part of the All About Me Assessment) will be reviewed by each Keyworker to ensure each residents healthcare needs are identified and recorded. 15/07/2016

B. Health action (care) plans will be reviewed to ensure each health need is supported by a corresponding health action (care) plan. 15/07/2016

C. The documentation to support healthcare concerns will be followed up and included in residents personal plans. 15/07/2016

Proposed Timescale: 15/07/2016

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:
One PRN medication did not have the indications for use clearly stated on the prescription sheet.

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

Please state the actions you have taken or are planning to take:
Each cardex will be reviewed to ensure each PRN medication has the indications for use clearly stated.

Proposed Timescale: 29/04/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The policy on the disposal of unused medications in the centre needed to be reviewed.

There was insufficient storage available in the medication press for unused medications that were to be disposed of in the centre.

9. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
A. A local procedure will be developed to support the disposal of unused medication. 31/07/2016

B. An additional medication press will be purchased for the storage of unused medication that are awaiting disposal. 03/06/2016

Proposed Timescale: 31/07/2016

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 annual review for the centre did not contain evidence that family and residents had been consulted with as part of the review.

10. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
The annual review will evidence the consultation that takes place with residents and their family members through providing an overview of the following; residents meetings and correspondence with families.

Proposed Timescale: 30/07/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate staff numbers in the centre in the evening times and the staff numbers did not reflect what was written in the statement of purpose.

The staff numbers in one area of the centre were not sufficient to meet the social care needs of residents.

The staff numbers in one area of the centre were not sufficient to implement a safeguarding plan for one resident.

11. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The staff numbers in one area of the Designated Centre have been reviewed. With immediate effect on an interim basis additional staffing has been provided in one house to allow for double cover in the evenings (Monday to Thursday) when all ladies are in the house. This will facilitate the implementation of the safe guarding plan in the house. Further to this a full review of all 3 rosters within the DC will be conducted in consultation with staff in order to meet the assessed needs of the residents. 02/09/2016

Following the review of the rosters The Statement of Purpose will be reviewed to reflect the outcome. 02/09/2016

The Statement of Purpose has been updated on an interim basis to reflect the current staffing levels in the Designated Centre. 10/05/2016

Proposed Timescale: 02/09/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were gaps evident in some staff files on employment history details.

12. 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: The staff files will be reviewed to ensure full employment history details are present for all staff members.
Proposed Timescale: 16/05/2016